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# Evaluation of Cal MediConnect: Results of Focus Groups with Beneficiaries

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To read a summary of focus group key findings with recommendations, go to [http://www.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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# INTRODUCTION

## Background

Over 9.6 million seniors and adults with significant disabilities in the United States (US) are dually eligible for Medicaid and Medicare.<sup>\*</sup> They represent beneficiaries with the lowest incomes and, on average, the most complex care needs and the highest care utilization. Not surprisingly, they account for a disproportionate share of spending in both programs. The *Patient Protection and Affordable Care Act* gave the Centers for Medicare and Medicaid Services (CMS) new demonstration authority to implement and test programs to align the financing and/or administration of Medicaid and Medicare for dually eligible beneficiaries. Twenty-six states submitted applications to implement a “dual financial alignment” demonstration, and CMS has finalized Memorandums of Understanding (MOUs) with 12 states.<sup>† ‡</sup> CMS predicts that as many as two million dually eligible beneficiaries in the US may be included in state alignment demonstrations.<sup>§</sup> Enrollment in the first demonstration in Massachusetts became effective in October 2013, with more states following in early 2014.

California’s dual alignment demonstration, called the [Coordinated Care Initiative \(CCI\)](#), was designed as a capitated managed care model. Existing Medi-Cal managed care plans in seven selected demonstration counties created new “duals” products called Cal MediConnect (CMC). The first counties began passively enrolling eligible beneficiaries in CMC plans in April 2014.

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<sup>\*</sup> The Kaiser Commission on Medicaid and the Uninsured. October 2012. *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>.

<sup>†</sup> California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, and Virginia will test capitated financial alignment models, Washington will test both a capitated model and a managed FFS alignment model, Colorado will test a managed FFS model, and Minnesota will test the integration of administrative functions without financial alignment. Most states limit their demonstration to certain geographic regions and many focus on different beneficiary population segments: Massachusetts focuses on non-elderly people with disabilities, Washington’s managed FFS model targets high cost/high risk beneficiaries and the capitated program targets long-term services and supports recipients, New York focuses on beneficiaries receiving extensive long-term services and supports [not just people in nursing homes] without regard to age, Minnesota and South Carolina target elderly beneficiaries, and California, Colorado, Illinois, Michigan, Ohio, Texas, and Virginia focus on both elderly and non-elderly beneficiaries.

<sup>‡</sup> 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>.

<sup>§</sup> The Kaiser Commission on Medicaid and the Uninsured. January 23, 2014. *State Demonstration Proposals to Integrate Care and Align Financing and/or administration for Dual Eligible Beneficiaries* (January 23, 2014), available at <http://kff.org/medicaid/fact-sheet/state-demonstration-proposals-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/>.

By February 2016, over 124,000 dually eligible beneficiaries were enrolled in Cal MediConnect health plans.\*\*

Once enrolled, dual eligible beneficiaries have all Medicare and Medicaid services coordinated through one health plan and integrated under one payment system. Most strikingly, the CMC plan is financially responsible for all long-term services and supports (LTSS), including both institutional care (skilled nursing/rehabilitation) and home- and community-based services (home care and adult day care), creating an incentive to privilege less expensive home service over institutional care. Though county social services are still responsible for assessment of In-Home Supportive Services (IHSS) eligibility, the CMC health plans pay for the service and have developed channels of communication to request additional home care hours. Three new benefits provided to Cal MediConnect beneficiaries include: care coordination, vision care and non-emergency transportation services. Some plans provide increased dental benefits while others do not. Additionally, most CMC plans are offering “Care Plan Options,” which is a term that describes plans’ ability to pay for a variety of services (respite care, home modification, etc.) that are intended to help beneficiaries prevent forced moves to higher levels of care. If implemented well, these may also play a key role in helping beneficiaries rebalance services to privilege community living over institutionalization. Incentives to rebalance services away from more costly institutional care are one of the primary areas where costs savings are anticipated in the CCI.

Though specialty behavioral health is “carved out” in California and continues to be provided by county behavioral health services, Cal MediConnect plans are responsible for providing non-specialty behavioral health and “coordinating” all behavioral health services for beneficiaries. And some plans have also taken steps to include more behavioral health providers in their own networks, potentially increasing access to these services for beneficiaries who need them.

Beneficiaries can choose not to participate in Cal MediConnect. They had the option of “opting out” before they were enrolled, or disenrolling later. Those who don’t join Cal MediConnect can keep their original Medicare, but they are still required to join the Medi-Cal managed care (MMC) plan through which their Medi-Cal services, including medical care, LTSS, and behavioral health services, will be managed. The opt-out rate in California was higher than anticipated, with about half of those eligible opting out and another 10% disenrolling.\*\*

The opt-out rate is variable in different counties and different populations. In San Mateo County (where Medi-Cal is part of a county organized health system and most dual beneficiaries had already been members of the MMC special needs plans before the transition) the opt-out rate was a very low 20%. Conversely, almost 70% of all beneficiaries in Orange County (the newest

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\*\* 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>.

county to transition) have opted out.\*\* The opt-out rate also differs by language and county.†† There are extremely high opt-out rates among Armenian and Russian beneficiaries (over 90% in some counties). The opt-out rate among Mandarin and Korean beneficiaries varied, but was higher than average in most counties. Farsi language speakers had a higher than average opt-out rate in Los Angeles and San Bernardino Counties but a lower than average opt-out rate in Santa Clara and Riverside Counties. Spanish speakers had by far the lowest opt-out rate, though it varied by county (26%-45%). These ethnic variations by county suggest an “ethnic enclave” effect where certain providers that serve specific ethnic groups may be giving different advice in different counties. Finally, over 60% of beneficiaries who use In-Home Supportive Services (a consumer driven, Medi-Cal home care program) opted out of Cal MediConnect.

### **Purpose of Focus Groups in Study Design**

Researchers at the University of California worked with a stakeholder advisory group during a 6-month planning period to design an evaluation of Cal MediConnect, California’s dual financial alignment demonstration. It was decided that the evaluation should begin by incorporating the experiences and voices of beneficiaries who had transitioned to Cal MediConnect or opted out. Qualitative focus groups with beneficiaries were planned with an overall objective of identifying the impact that the transition to Cal MediConnect had on beneficiaries’ experiences with access to, quality of, and coordination of care for beneficiaries dually eligible for Medicare and Medi-Cal. Additionally, focus groups were also designed to document the experiences of certain vulnerable groups which might not answer the telephone survey in sufficient numbers for statistical analysis, and to provide qualitative insights into meaning and context that can aid in the interpretation of quantitative survey data collected in the next phase of the analysis.

To accomplish these goals, researchers at University of California in Berkeley and San Francisco used input from the California Department of Health Care Services and a stakeholder advisory group to design focus groups with Cal MediConnect beneficiaries. Two pilot focus groups were conducted in the planning period to help refine the focus group design and questionnaire. The focus groups were designed to include beneficiaries from six of the seven Cal MediConnect counties (Orange County was delayed in their implementation and was excluded from the focus groups). They were also designed to include a diverse population of dually eligible beneficiaries, including seniors, younger people with disabilities, and those who used specific services such as In-Home Supportive Services (IHSS) and the new Cal MediConnect care coordination benefit. In addition to the 14 focus groups, some individual telephone interviews were conducted with beneficiaries in harder-to-reach populations such as 1) those using behavioral health and 2) homeless or marginally housed beneficiaries. The semi-structured focus group discussion guide was designed to gather input on domains of interest to both researchers and stakeholders, including: notification and enrollment into Cal MediConnect, health care utilization, factors

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†† Cal MediConnect Opt out Breakdown by Language, Ethnicity and Age by County as of November, 2015 <http://www.calduals.org/wp-content/uploads/2015/12/November-Detailed-Opt-Out.pdf>.

contributing to satisfaction and dissatisfaction, experiences with and changes to access, quality and care continuity, care coordination, long-term services and supports, and experiences around opting out of the demonstration. The focus groups also explored beneficiaries' knowledge and understanding of different aspects of the Cal MediConnect program.

## METHODOLOGY

### Target Populations and Sites

Focus groups and in-depth interviews were conducted between May 2015 and November 2015 in six demonstration counties in California, including: San Mateo, San Bernardino, Santa Clara, Riverside, San Diego, and Los Angeles. Twelve focus groups were held with dually eligible beneficiaries who were enrolled in a Cal MediConnect plan and two focus groups were with beneficiaries who opted out. Some focus groups specifically included seniors, people with disabilities, or a combination of these populations. Others focus groups targeted users of specific services—In-Home Supportive Services and health plan care coordination services. (Care coordination users were defined as people who had been in contact with their care coordinator at least twice per their health plan's records.) We decided to conduct in-depth telephone interviews with beneficiaries who were using behavioral health services instead of a focus group to allow us to sample from multiple counties (San Bernardino, Riverside, San Diego). We conducted one telephone interview with a beneficiary in a Cal MediConnect plan in Los Angeles who had recently experienced homelessness as well. Nine focus groups and all interviews were conducted in English; three focus groups were in Spanish, one in Mandarin, and one in Cantonese. Table 1 below demonstrates the county, language, specific populations, and number of beneficiaries in each focus group.

**Eligibility:** The target population for the focus groups was beneficiaries who were dually eligible for Medicare and Medi-Cal and who were eligible for enrollment in Cal MediConnect in one of the demonstration counties. Members of the target populations were eligible to participate in the focus groups if they were aged 18 or over, currently enrolled in a Cal MediConnect Health Plan, or had opted out or disenrolled from the program. An eligible participant could nominate “health care proxies” to represent them at the focus group. Proxies were eligible if they were 18 years or older and made health care decisions for the beneficiary. In San Mateo County (a county organized health system) most beneficiaries had been in special needs plans in the Medi-Cal Managed Care (MMC) plan before the transition to Cal MediConnect. In other counties, we gave preference to beneficiaries who had been in original Medi-Cal (fee-for-service) as opposed to an MMC plan before their enrollment in Cal MediConnect because pilot focus groups showed that those who had been in MMC before the transition were less likely to perceive many changes.

**Table 1. Focus Groups/in Depth Interviews by Target Population, County, Language, and Number of Participants**

<b>Population</b>	<b>County</b>	<b>Language</b>	<b>Number of participants</b>
People with disabilities	San Bernardino	English	10
In-Home Supportive Services (IHSS) users	San Bernardino	English	12
Care coordination users	San Bernardino	Spanish	8
Opted out/Disenrolled	Riverside	English	8
Care coordination users	Riverside	English	11
In-Home Supportive Services (IHSS) users	Riverside	Spanish	5
Seniors	Los Angeles	English	9
Opted out/Disenrolled	Los Angeles	English	8
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
		<b>TOTAL</b>	<b>120</b>



## Participant Recruitment

We used a combination of methods for participant recruitment to ensure the least amount of bias. For nine of the focus groups, we worked with two different Cal MediConnect health plans to send out letters to eligible participants. Working with Cal MediConnect health plans was especially important for focus groups that included users of specific services such as IHSS or care coordination as the plans were able to send out letters only to individuals known to use the service. For five focus groups and in-depth interviews, researchers partnered with community organizations that served the target population. Using flyers provided by the research team, community partners helped get the word out to eligible clients who might be interested in participating. In some cases, we used a combination of methods. The recruitment flyers or letters asked potential participants to call, text, or email the research team to learn more about the study and get screened for eligibility. Relay communication was available for any individuals who were Deaf or hard of hearing.

## Participant Screening, Informed Consent, and Focus Group/Telephone Interview Procedures

Beneficiaries interested in participating contacted the research staff by phone, email, or text message. Research staff screened potential participants by phone to ensure they were eligible to participate (see Appendix A: Focus Group Screening Form). To ensure that the focus groups did not exclude beneficiaries with mobility barriers, taxi rides were provided for participants who required assistance with transportation. Beneficiaries whose functional limitations prevented in person attendance were also offered telephone interviews in some cases.

Just prior to the focus group, research staff obtained informed consent from focus group participants and administered a brief demographic and health services utilization survey (see Appendices B and C: Focus Group Consent Form and Pre-survey).

Focus groups were audio recorded and later transcribed (and translated into English if necessary). For participants who were interviewed over the telephone, verbal consent was obtained. Telephone interviews were not audio recorded.

## Analysis

Content analysis of the qualitative data was conducted by the research team using Dedoose<sup>##</sup> software, a web-based application designed for qualitative data analysis. The research team created an initial codebook including codes representing themes that were expected to emerge from the data based on 1) research questions, 2) previous research, 3) input from the advisory group, and 4) observation of the focus groups. Three members of the research teams used the initial codebook to independently code three focus group transcripts. The team then met to

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<sup>##</sup> <http://www.dedoose.com/about-us/>

review the coding and discuss areas where codes were in disagreement. The codebook was iteratively revised to merge similar codes, create new codes, and refine all code definitions. Three new transcripts were chosen and inter-rater reliability tests were performed. After the first test, the kappa score was 0.60. The research team met to again refine the codebook, merge and expand definitions of codes. Subsequent tests of inter-rater reliability reached 0.86 to indicate that agreement among independent coders was satisfactory. The final codebook was then used to code all of the other transcripts (see Appendix D: Focus Group Codebook). Excerpts from each code were exported and the most common themes were summarized for this report.

## RESULTS

### PARTICIPANT CHARACTERISTICS

A total of 120 total beneficiaries from six counties (21% Riverside, 26% San Bernardino, 10% San Diego, 20% Los Angeles, 8% Santa Clara and 16% San Mateo) participated in a focus group or in-depth interview (Table 1). Most participants (68%) participated in focus groups or interviews in English. In addition, 16% attended a Spanish-speaking focus group, 10% a Cantonese-speaking focus group, and 6% a Mandarin-speaking focus group.

In most cases, beneficiaries represented themselves; only 7.5% of participants were health care proxies. Participant ages ranged from 24 to 92 with a mean age of 66. Sixty-five percent were seniors (over age 65). The majority of participants were female (68%). The racial and ethnic composition of the focus groups/interviews were as follows: 32% Latino, 31% African American, 20% White, 9% Asian, 6% more than one race, and 1% some other race. Over half of participants lived alone (57%). A quarter of participants (25%) had not graduated from high school; 17% were high school graduates; 37% had attended some college; and 21% had graduated from college or attended graduate school.

Most participants felt they were in fair (51%) or poor (25%) health overall. The majority of participants (82%) self-reported having a disability with more than a third (35%) reporting more than one type of disability. The most common types of disability were physical disabilities (e.g., arthritis; 48%), chronic illnesses (e.g., diabetes; 24%), and mental health disabilities (17%). Participants were asked about medical services used in the past six months. All but five had seen a primary care provider during that time period, and nearly half (48%) had seen a primary care provider three or more times. Eighty-three percent had seen a specialist. Twenty-one percent reported using behavioral health, 22.5% used health plan care coordination, 46% used In-Home Supportive Services (IHSS), 32% used durable medical equipment (DME), and 26% used medical supplies. Half (50%) were taking seven or more different prescription medications. Twenty-one percent said they usually or always have a hard time reading or understanding written materials about health care.

**Table 2—Focus Group/Telephone Interview Participant Characteristics**

	n (%)
<b>Type of Participant</b> (n=120)	
Beneficiary	111 (92.5)
Proxy representing beneficiary*	9 (7.5)
<b>Age</b> (n=112)	
24 to 44	10 (8.9)
45 to 59	23 (20.5)
60 to 64	6 (5.4)
65+	73 (65.2)
<b>Gender</b> (n=112)	
Female	76 (67.9)
Male	36 (32.1)
<b>Education</b> (n=100)	
Did not graduate high school	25 (25)
Graduated high school	17 (17)
Attended some college	37 (37)
Graduated from college or attended graduate school	21 (21)
<b>Language</b> (n=120)	
English	82 (68)
Spanish	19 (16)
Cantonese	12 (10)
Mandarin	7 (6)
<b>Health Literacy/Difficulty Reading Written Health Information</b> (n=105)	
Never have difficulty	40 (38.1)
Sometimes have difficulty	43 (41)
Always or usually have difficulty	22 (21)
<b>Household Composition</b> (n=117)	
Lives alone	67 (57.3)
Does not live alone	50 (42.7)
<b>Self-rated Health</b> (n=112)	
Excellent or good	30 (26.8)
Fair	57 (50.9)
Poor	25 (22.3)
<b>Number of Visits with Primary Care Provider Last 6 Months</b> (n=116)	
0	5 (4.3)
1	14 (12.1)
2	40 (34.5)
3 or more	57 (49.1)
<b>Disability (Self-reported)</b> (n=94)	80 (81.6)
<b>Type of Disability</b> (n=94)	
Intellectual disability	1 (1.0)

Developmental disability	1 (1.0)
Mental health disability	17 (17.3)
Brain injury	11 (11.2)
Physical disability	47 (48.0)
Blindness/visual impairment	8 (8.2)
Deafness/hard of hearing	2 (2.0)
Substance abuse	1 (1.0)
Chronic illness	23 (23.5)
Other type of disability	4 (4.1)
Missing/did not specify	3 (3.2)
<b>Number of Disabilities Reported (n=91)</b>	
0	14 (15.4)
1	48 (52.7)
2	22 (24.2)
3	6 (6.6)
4	1 (4.4)
<b>County (n=120)</b>	
San Bernardino	31 (25.8)
Riverside	25 (20.8)
Los Angeles	24 (20.0)
San Diego	12 (10.0)
San Mateo	19 (15.8)
Santa Clara	9 (7.5)
<b>Care Coordination User (n=117)</b>	27 (22.5)
<b>IHSS User (n=117)</b>	55 (45.8)
<b>Enrollment Status (n=120)</b>	
Enrolled in Cal Medi-Connect	104 (86.7)
Opted out or disenrolled	16 (13.3)

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

## FACTORS CONTRIBUTING TO SATISFACTION AND DISSATISFACTION WITH CAL MEDICONNECT

### Factors Contributing to Satisfaction with Cal MediConnect

Focus group participants who had enrolled in Cal MediConnect (n=104) were asked at the beginning of the focus group to rate their overall satisfaction with the program on a scale of 1 to 10. The median rating of satisfaction with Cal MediConnect (CMC) was 8. Though many beneficiaries went on later to discuss some problems they had in the program, the overall satisfaction was quite high. Generally, when discussing reasons why they were satisfied with the program, there were several themes that emerged which are summarized below.<sup>§§</sup>

***Simplified health insurance:*** Some beneficiaries said that they liked using only one insurance card for all their health care needs. For them, this simplified the experience of accessing health care.

*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.*

***Continuity with providers and services:*** Another commonly cited reason for satisfaction with Cal MediConnect was that nothing about their health care changed. In other words, they had continuity with the same providers, medications, medical equipment, and other services after the transition to Cal MediConnect. This was especially true in San Mateo County, where most beneficiaries had been in special needs plans before the transition. Being able to keep a trusted provider or remain on the same medications was a major factor contributing to beneficiary satisfaction.

*Oh. We heard it from other counties that after the switch, they were forced to stop taking the original medication, and started taking other medication. Not us. We did not experience these situations. In general, they followed whatever we were prescribed. They would not change medication.*

***Lower out-of-pocket expenses:*** Another major factor contributing to satisfaction was the out-of-pocket amount beneficiaries were paying for health care (i.e., cost sharing). Many beneficiaries who expressed satisfaction specifically noted that they were happy under Cal MediConnect because they were paying either nothing out-of-pocket or their out-of-pocket payments had decreased. This was especially true for some beneficiaries who had been in Medicare Advantage plans before the transition.

*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 you don't have to pay the copay now either, huh.*

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<sup>§§</sup> Most of these factors contributing to satisfaction are summarized in more detail in corresponding sections later in the report.

*I really was very grateful that I was on [CMC health plan]. It was a godsend for me. Um, they helped me find my doctors, and um, there's no copays for hospitals or, um, benefits and stuff like that. Cause I was on [Medicare Advantage] and there was, um...it was...to the point it was gonna cost me the hospitalization. And things like that. So it was of the right time that Medi-Cal told me to enroll in a managed care plan.*

**Satisfaction with care coordination:** Beneficiaries who used the plan care coordination reported great benefits from the services, and care coordination was a commonly cited reason for satisfaction. Often beneficiaries stated that their care coordinator from the Cal MediConnect plan had facilitated access to specialty care, durable medical equipment, and additional long-term services and supports (LTSS) like In-Home Supportive Services (IHSS). Additionally, care coordinators were often cited as great sources of information or emotional support.

*Again, the one that knows all those things is the social worker and she would go out of the way to help you and she is the one that coordinates for instance with the—with the non-soc—with the agency. Deal with getting those and she will help. Again with the social worker the key of everything.*

*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.*

*Yes, she called me and we did an over the phone interview, after my teeth are fixed, I will get a prescription for my eyes, and then she wants me to work on some other things...a sleep study and pulmonary test. She is really nice, confident and comfortable. She follows up on authorizations.*

**Someone to call at the plan:** Another main theme among the satisfied beneficiaries was that they spoke to someone on the phone at the Cal MediConnect health plan who was helpful and positive. Connecting with a person who was able to give satisfactory answers to questions and who had a good attitude was a common reason for satisfaction with the plan overall. Sometimes the person was a care coordinator, but just as often the beneficiary was referencing a one-time call to the CMC plan member services whom they reached through calling the number on the back of their card. A helpful and positive person on the member services line often was often noted as a positive benefit of the program.

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

*Yes, they have helped me a lot. Allowed me to change MDs easily. I had some billing issues and they went above and beyond to fix them.*

*[CMC health plan] doesn't really give you information unless you call and ask for it, and then they are really good about providing information.*

**Good quality of care from provider:** Beneficiaries' perceptions of quality of care were highly related to their satisfaction with the program. A common theme among beneficiaries who were satisfied with Cal MediConnect was that they liked their providers or were extremely satisfied with the care they were getting from their doctor.

*It is a very good plan. The doctor I visit is great. His medical skills are brilliant, and he is welcoming and patient, as if he is treating his own family.*

**Better access to care:** Many people expressed satisfaction with CMC because they felt they were getting easier access to care than they had previously. Beneficiaries who rated the plan highly cited better access to specialists, medication, durable medical equipment, dental care, health promotion classes, or long-term services and supports that they were receiving.

*I think everything is better. They give me better care. They tell me what they are doing to me. They are attentive of what I need.*

*Well I mean you get a lot more, uh, bargains on what you have to do for yourself. Like talking about goin' to the dentist, uh, uh, getting your medications, seeing your doctor, all kinds of things. It's just better.*

*I would describe it as special because I haven't had issues with it. Now, I can visit a specialist immediately instead of having to wait a long time.*

*I rate the plan 10 [out of 10] What I like the most is that they have helped me, sent me to a specialist, and did lots of diagnostic testing—things like that. They used to not send me to specialists as often.*

*It is a great help one has. For example, I also have asthma. They have sent me to classes for that. They give me a lot of services.*

*The reason that I would give it a 10 is the medicines that I used to struggle to get her and that now she can get.*

One homeless beneficiary, who had been very disconnected from services before the transition, said that Cal MediConnect got him medical care for the first time.

*[Care is] more coordinated [in CMC]; I didn't have any care before. They hooked me up with doctors, rehab, mental health, got psych meds.*

**Behavioral health services improved:** A very strong theme among behavioral health users was that the behavioral health services they were getting were much better under Cal MediConnect. This included better access to care (more providers to choose from, easier time getting psychiatric medication, quicker appointment times) as well as more coordination between behavioral health and other providers.

*To me the CMC is the best because of my mental health benefits. That is what I use the most and that is what I was most excited about... The mental health services were seamless, the benefits improved greatly and the providers seemed to understand [CMC health plan] well. I previously had to pay out of pocket.*

*I think mental health care is great. I am receiving better health care now, than we've received in 10 years. My level of physical health has shown an improvement.*

*Mental health is more coordinated, my doctors are communicating to each other.*



*Mental health care is now easy, no access problems. I receive one to one therapy (sometimes at home), psychiatrist visits, medications, groups. Mental health services are better. Some improvements with the counseling and medication, they appear to be managing my needs better, the amount of appointments appear to have increased.*

**Care is more coordinated across providers:** Another theme among those who were very satisfied with Cal MediConnect was the feeling that care is more coordinated—that providers are talking to each other—and this reduced the burden on the beneficiary to relay information between providers.

*I just know that like, I'll go to my specialist—to see my specialist—and they take care of connecting with my primary doctor to get my referral, and then I just get a letter in the mail saying, "Here's your referral from this month to—this month you have to go to your—" and I hadn't done anything. I don't have to get on a phone and make that happen. They make it happen for me.*

*[Before CMC] I had to inform [doctors] exactly what was happening. And not now. Everything is through the computer. They just enter it in the computer and they start to—"ah, you have this, you have this other thing, you have this other thing." There's no need for so much paperwork. The advantage that it has is that one avoids a lot of questions that maybe one doesn't even remember one of the questions.*

**Initial skepticism turned into satisfaction:** Some beneficiaries described feeling apprehensive about the transition initially, and even considered opting out, but explained that after using their Cal MediConnect insurance they became more comfortable and happy with their care.

*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.*

**Moderator:** So you did consider opting out? **Beneficiary:** Yes at one time. They—the first time...I tried to keep my Medicare and my Medi-Cal straight, ... I didn't have any experience and I thought with my Medicare, Medi-Cal straight—I'd have a better choice to go to different doctors. **Moderator:** And what has changed?—if you were today to be asked to enroll would you choose to opt out? **Beneficiary:** No. Well because the experience I have with this year with the—with [CMC health plan]. For me it's working.

## Factors Contributing to Dissatisfaction with Cal MediConnect

While generally experiences with Cal MediConnect among focus group participants were more positive than negative, some beneficiaries did describe negative experiences with the plan. This was usually in the context of discussing how their care had changed since they switched from regular Medicare or Medi-Cal. As is noted below, many problems that beneficiaries mentioned were resolved over time. Below we describe some of the most common reasons for dissatisfaction with Cal MediConnect.\*\*\*

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\*\*\* Many of these themes around dissatisfaction are discussed in more detail later in corresponding sections of the report.

**Having to switch doctors:** A common reason for dissatisfaction with Cal MediConnect was beneficiaries being unable to continue seeing their regular doctor because that doctor was not participating in CMC, and were thus, out of network. This was particularly difficult for beneficiaries who were forced to change after having a long-standing relationship with their doctor. Some beneficiaries who could no longer continue seeing their doctor stated that they had difficulty finding a new doctor who took their CMC insurance. Other beneficiaries did not like their new doctor, and for that reason, rated the entire plan very low. Additionally, some beneficiaries who did not like their new primary care doctor did not know that they had the right to switch doctors.

*I couldn't even keep my doctor that I was with for 17 years.*

*Um since—since they changed my insurance I'm no longer able to see my—my regular doctor because they don't accept that insurance. And then they put me on [CMC health plan], uh, um, and they sent me a book of listed physicians in a book where I had to find another doctor and almost every doctor on there were not accepting new patients.*

*And, and uh, when I had to change to [CMC health plan] I did find a place that accepted my insurance and 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. But not with [CMC health plan]. They always help me.*

**Prescriptions or medical supplies not covered:** Some beneficiaries expressed dissatisfaction because they found that services such as medical supplies or prescription medications that had been previously covered were not covered under CMC. Often, and most disturbingly, they were sent bills and asked to pay for provider visits or services they thought (or were told) were covered. Beneficiaries often described seeing providers whom they were told would take Cal MediConnect, only to find out later that they weren't covered when they received a bill. One beneficiary believed that the stress of receiving these bills has contributed to her declining health. Other people experienced a change in their prescriptions or supplies that reduced the quality or amount they received and, as a result, they were forced to pay for the rest out of pocket.

*My health care is—it's declined since being put into this program. I've had a very difficult time getting what I need and, uh, being told that I can get this and that it'll be paid for and then receiving a bill and then being disconnected every time I've tried to ask them about getting paid. Yeah.*

*I had problems with, with uh, filling prescriptions. Um, and they had prescriptions they were sent I was covered by—it was covered by Medicare. And uh—then—bill Medicare and then—then Medicare was—Medi-Cal was saying bill Medi-Cal. I mean, bill Medicare for my prescriptions. I wasn't able to get my prescriptions ...*

*I became incontinent because they took out my bowels twice. And so I have to wear—I have to have diapers, basically. So you go 15 to 30 times a day. What—they—and they give you a supply for four or five. Okay. So how do you—how do you pay for all of those diapers, all of these creams, all of these... [CMC health plan] doesn't pay for it. And it's*

*very, I mean, it's very painful. It's very—you know, you have to have—you know. Think about it.*

*...the doctor they set me up with, um, referred me to the optometrist, who they were adamant was covered—and I asked several times, "Is this person covered?" And they weren't, um, because I got the letter. And I fought that.*

*And I also had the same optometry problems and I was told this person was covered. I checked, I re-checked, and then I received a bill and I can't pay that bill. And they're harassing me now. [Laughs]*

*They are giving me the very cheapest kind [of test strips] and some of them do not work so, you know, I'm going through bottles and it's like, "Oh well, this strip doesn't work" and sometimes the machine doesn't work, and I kind of wonder—am I getting the right numbers? Because they've chosen the very, very cheapest. Yeah.*

*I'm actually paying more now. Yeah it's about—it's about \$30. Which I have—yeah. [Laughs]*

**Harder to see specialists:** Another commonly cited experience among those who were dissatisfied was decreased access to specialty care. Some had more trouble seeing specialists after the switch to CMC because of more stringent rules from the managed care plan about appropriate referrals, and the severity of their condition did not meet requirements for specialty care. Others found that many specialists did not take their CMC plan.

*Well, yeah I wasn't happy with, uh, [CMC health plan]. I had some issues I needed to be taken care of and, um, they denied the—me to see a specialist because it—the—my lump wasn't big enough. It was like, "Oh it's not two—it's less than two inches, well, I'm sorry we can't see you." And so it's like, little things like when it comes to finding a specialist.*

*Well, for me, [I rated CMC] a three [out of 10] Because I had some really difficult things happen. Like, I had problems with my eyes. And I needed to find an...ophthalmologist? Optometrist. And, um, I kept—I had to call and find the—the—um, the optometrist. And half of them didn't accept the Medi-Cal.*

**Needing service authorizations delays care:** One of the most common reasons for beneficiary dissatisfaction with Cal MediConnect was the new requirement to get approvals and referrals for services such as specialist visits or lab tests. Those who had fee-for-service Medicare prior to the transition were not used to having to wait for a referral. Some felt this process reduced their autonomy, some felt that the process took too long, and others were annoyed because there were often glitches with the process (e.g., going to an appointment only to find that the authorization was not sent).

*Um, why does the primary care physician have to approve everything? Yeah, it um...like I said, I use the word "restrictive." I—I—yeah. So it's—I have to wait for the answer, what he chooses and that, it's a little bit, you know, it prolongs the thing. You know. Well, um, like if I had to take blood work, he has to approve it. He has to find somebody—that, all that stuff.*

*The doctor approvals to see a specialist. In that area they need some improvement. — From the time you need it to the time you get the services, I think, is a little long.*

*When I have to go to a specialist, [primary care doctor] doesn't send the authorization and when I go to the appointments, I have to come back because they don't have the approval.*

**Lack of communication between health plan and providers:** Another reason beneficiaries cited for being dissatisfied with Cal MediConnect was the poor coordination or communication between the health plan, providers, and medical groups. This was a more common problem early in the transition when the plan and the provider were “not on the same page.” The lack of coordination resulted in the plan telling the beneficiary that something was covered or that a provider accepted their plan, only to learn later that the service was not covered.

*The only challenge was somehow the medical staff were confused about whether I was able to get services from them. Instead of straight Medicare, it became [CMC health plan]. I was going to the same place and they were not understanding for a while.*

*It takes a little longer now...the problem is the coordination between the insurance company and the doctor's office.*

*There could have been cohesiveness. I mean some—somebody—yeah. I'm not sure. It's just that there's a lack of communication throughout the entire—all the companies all these—the—the doctors, Medi-Cal, MediConnect, uh, [CMC health plan] who—who's dealing with—you know, it's just none—nobody knows what anybody else is doing—And they say that "It's their fault. It's their fault, their fault." And everybody else says "It's somebody else's fault, call them."*

*Um, I went to the regular pharmacy. They—they, uh, did fill the prescription and it—then they told me that uh, that [CMC health plan] says that Medicare is my primary and Medicare says that [CMC health plan]'s my primary insurance. And both were listed as my primary insurance. So they wouldn't fill the prescription.*

*The worst thing for me, though, was that the medical group ... Even though MediConnect told me that that group that I had been going to will be taking [CMC health plan], when I called them—they had no clue. The people that verify the insurance, they were telling me that they were not, um, enrolled with [CMC health plan]. So that made it very difficult.*

*The group that I'm assigned to, [medical group name], is the one that is denying that. Because they want me to go their group and I started my cancer treatment since three years ago with [hospital name] ... I don't wanna go through this rinky dinky small place for my cancer treatment.*

**Health plan member services not helpful.** Another reason for dissatisfaction was when a beneficiary called the member services phone number and did not receive the help they needed.

*Well, I called them to help me... find a referral for the... optometrist. And um, I—she told me that I would have to do it on my own and to open up the book and call the numbers. And I was—I was callin' because I needed help with that. But...*

*So I called them and, uh, they just kept passing me to another person. I was on hold for hours. And then they disconnected me. And then I couldn't get back in. Every time I tried to call, it's like my number had been blocked.*

*You know when I've called [CMC health plan] ...I really just never get anywhere with them.*

**New providers were farther away:** Another factor contributing to dissatisfaction was that the beneficiaries' new doctors, laboratories, or pharmacies were sometimes geographically harder to get to than previous providers.

*That's what I would say. For me with my [CMC health plan] I don't know it's almost like a—everywhere I go it's like a trap. Like, my blood draw's on one side of town, my psychiatrist is on another, my doctor's on another, and it's like it's—it's um... Exhausting.*

*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.*

**Disempowerment and resignation:** Some beneficiaries who were dissatisfied with Cal MediConnect describe feelings of disempowerment or resignation – especially in regards to the passive enrollment and perceptions of lack of choice. Some said they enrolled in a Cal MediConnect plan because they didn't see that they had any other choice. Others didn't know they could switch plans or choose another doctor. Similarly, among those who opted out, having the autonomy to choose specific services and providers was a key motivator.

*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. So, that's why one feels a bit out of control.*

*Well, I was using my straight Medicare and Medi-Cal because I have the A and the B also. And I think I got a letter from them. And you know. 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.*

*Me, I made a call and they said to me, 'you don't have another choice. You have to keep that one.' I said, 'but I don't want to switch my insurance.' For the same reason that there are many issues with the doctors.*

*I felt more free the way I was in the beginning. With more freedom, because I would go to whichever specialist I wanted, anyway, without having to wait for anyone. Now I feel like I have to depend on a dad and a mom after growing old—after growing old. And I don't agree with that. I know there are a lot of people who have abused of these services, and perhaps that's why things have changed, so they can have some control.*

*And then they send you this booklet that is totally confusing. And, I gave up. And I don't like—I don't like it, but I was like, at their bidding.*

*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. Or I can have, uh, a choice of a specialist that I felt maybe could, uh, you know they have more*

*experience or more qualified versus someone who's in their group who, maybe, I have no choice. I have to go to that person.*

**Disruptions and resolution:** As would be expected in most transitions of delivery systems, some beneficiaries reported disruptions as a result of the switch to Cal MediConnect. Some of the most common disruptions were due to changes in providers, medications, or medical supplies. As stated above, beneficiaries noted that in the beginning, the plan and the provider's office were often miscommunicating. But there were also many who reported that those disruptions were limited to the time period immediately following the transition, and that most disruptions were resolved to their satisfaction after some time in the plan.

*In the beginning I was very skeptical. Then I had some disruptions and some—Turned out to be perfectly.*

*[In] the beginning ... for me I had problems. Yeah, but it's good now.*

*I have a son who's disabled and the medication that he had been approved before with Medicare-Medi-Cal, I was shocked that ... the pharmacist said, "No." That he could not have it. So the doctor had to send in a pre-authorization request to let them know that this is the only medication that has really worked for him. And they approved it.*

*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.*

*There are not many [doctors] to choose from and, um, I've actually started to see somebody over this past week, ... she's in the same office. And she's a little bit better. So I'm happier with her.*

*The problem was when there was this, uh, change of uh, of system. Nobody knew where—what we're doing. The doctor's office didn't know why they were doing the insurance company. They had no clue. But now they are settled, everything is smooth.*

*With HMO, of course, you have to get the approval from the company, but, uh, that is the only drawback. But once you are with the primary doctor, the primary doctor works very well.*

## ENROLLMENT IN CAL MEDICONNECT

### Information and Notification

The focus groups explored how beneficiaries first learned about their enrollment in Cal MediConnect and whether they found the information they received useful. It also explored how beneficiaries sought other information about the different plans they had to choose from.

**Notification letter:** DHCS mailed 4 different letters to beneficiaries at intervals beginning 90 days before they were enrolled in Cal MediConnect. These letters told them the name of the Cal MediConnect plan they were assigned to and informed them they had the option to decide against enrolling or changing plans. Beneficiaries were provided with phone numbers of the enrollment contractor and the plans so they could seek more information about the plan they were enrolled in. The majority of focus group participants remembered getting these notification letters from DHCS and most said that is how they learned about the new program. 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 changes to their care. Confusion resulting from the notification letter often caused misgivings about the program.

*I received a letter, um, and...it was confusing. You know. It just felt like the buck was being passed here and there and it—it was just confusing. I wasn't sure what was going on. I didn't have a good feeling about it.*

Some beneficiaries said that the letter they received from DHCS did not provide enough information for them to discern 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.

*No, I read the letter. It was just saying you were on it. That's it. It didn't give any information.*

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

*And everybody have different medical issues. Like ... with her wheelchair or whatever and everybody have different things, so we wanna know what's gonna be covered and not covered, so we can make a decision on which way we need to go to make sure things are covered for us.*

*I guess I would just add a little bit. 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.*

While most beneficiaries said they received at least one letter from DHCS about the transition to Cal MediConnect, a few said they did not receive a letter at all. Some speculated it was because DHCS did not have their current address.

*They didn't send nothing. Next thing I know I was enrolled!*

*It's because I moved. They may have sent [the letter] to my old address. I didn't receive a letter.*

A few beneficiaries, however, felt the letter provided an appropriate amount of information since the phone numbers were provided. These beneficiaries understood that, after reading the letter, they could call to obtain more specific information about their own situation.

*May I say something? I think the letter was very general. They are trying to build up basic information, but everybody has different questions ... So they say that if you have further question, if you need more help... Call this number. So, otherwise there would be a big bible type of thing for everybody's concerns. **Moderator:** So in your mind... it was enough? **Beneficiary:** It was, to me...*

After receiving the notification letter, several beneficiaries felt they did not have sufficient time to make a decision.

*They—they gave us a—a date that—that we had to either opt-out or enroll. **Moderator:** And that date, did that feel like a reasonable date to you? **Beneficiary:** No. It was within a few months... **Moderator:** And that wasn't enough time to make the decision? **Beneficiary:** Not to go through all of their medications and, uh, feel comfortable. (Beneficiary who opted out)*

**Other forms of notification:** A minority of beneficiaries did not learn about Cal MediConnect from a letter. Of those, most found out that they were enrolled in the CMC program from their primary care provider or the provider's staff. In some cases, the provider or staff member told the beneficiary ahead of time. In a few cases, the beneficiary found out that they had been passively enrolled in a CMC plan when they went in for or tried to schedule an appointment and were told they could no longer see that provider. Another found out she had been enrolled when she received a bill for supplies from her old provider. Others first were notified when they received a call from the health plan.

*I don't even remember getting the letter. All I remember is that I called to make her an appointment with her usual doctor who she's had for 20 years at [HMO name] and they said, "Sorry, she's not a member of [HMO name] anymore." It was—she was removed from [HMO name]. So I said, "Well, she needs to see the doctor. What if there's an emergency?"*

*—the way I found out was the, uh, the medical facility I used to go to called me and I had to make an appointment with them to see the doctor and they told me that they did not accept my insurance. That's how I found out I had been switched.*

**Suggestions for improving notification and enrollment:** Some beneficiaries said they would have preferred to have a more direct personal contact in addition to or instead of a mailing, (e.g., a phone call or an in-person meeting). Few seemed to have heard about or attended the in-person presentations about CMC.

*I would send a letter to the people. Like, every person. I would let them know what's happening and then, like you said, set up, um, a—a program or a meeting time we could go and get information like this. It would be like, set up, "Okay this is what's happening, this is your options." And we didn't even know why, you know, it was like a draft. You know, we had no idea it was coming.*



*And um, I don't think I received a phone call from them... **Moderator:** Would that have been something you would have liked? **Beneficiary:** Yeah, yeah. I would have liked that.*

***Moderator:** What other information would have been helpful during the notification and enrollment process? **Beneficiary:** A home visit or a call from someone to explain the options.*

**Medicare Advantage plan marketing efforts:** Some beneficiaries mentioned that at the same time they were getting notification letters from DHCS, they also were contacted by or saw advertisements directed at dually eligible beneficiaries for Medicare Advantage plans. While Cal MediConnect plans are prevented from using enrollment brokers for CMC, plans do pay these brokers to recruit members into their Medicare Advantage products. The simultaneous marketing of Medicare Advantage plans made the notification period more confusing for some beneficiaries.

*People—people started callin' me and different um, um different HMOs started calling trying to get you to sign up with them too. And you—and everybody that—*

*I went to another insurance—[Medicare Advantage Plan]. They had a commercial that said, “Get the most out of your Medicare and Medi-Cal.” I called them. Everything was lies. There was a \$40 copay to see the doctor and I had to pay for dental insurance. They just lied. I didn't see a doctor for a month. I called Medicare. They told me to go to the social security office and tell them to put back on just Medicare and Medi-Cal.*

*When I asked for—for help, ...the person that came to my house was through [Medicare Advantage plan] and then that really messed everything up and I ended up going to—there were only a few doctors I could choose from and they—there were three I tried. None of them were any good. The two of them knew nothing about Type I Diabetes, um, it was—it was kind of horrifying. And, um, so I found out that I could go back on [CMC health plan]. It was [sighs] it was really confusing and with the [Medicare Advantage plan] and [CMC health plan] with the H's and me not knowing much about insurance, that was confusing.*

*Now I spoke with a lady over the phone. I said, “I wanna remain the same,” and then she chose—she said, “I can't choose for you, but here are your choices.” And when she told me my choices, hearing a lot of the, uh, choice we had over TV commercials and things of that nature, I chose [Medicare Advantage Plan] because it was ...interesting. And I thought it would be the best for me personally.*

**Information from Cal MediConnect Plan:** After enrollment, many beneficiaries mentioned receiving materials from their health plan, e.g., books that listed providers (physicians, pharmacies) that were in the plan's network. Some beneficiaries complained, however, that the books included providers who were no longer in the network or that none of the providers in the book were accepting new patients. Some beneficiaries would have liked to receive information about medications covered by the plan. Some felt the books 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 eh CVS but then I have a whole booklet with all the pharmacies. Some of them eh in, eh, [different city].*

*Yeah. You know when too much information is thrown at me, I get overwhelmed.*

*Um, I received the packet. I flipped through it. I realized that I had to make a choice, but I didn't give it importance, because it was too much material for me to read and it didn't interest me.*

*[CMC health plan] sends us a big book every year, information printed on good quality papers. It is such a waste. [Everyone laughs] I never read it.*

*I got so much mail from [CMC health plan] and all that just stuff, uh, too overwhelming.*

### **Information Seeking about Cal MediConnect**

The focus groups also explored the many ways in which beneficiaries sought out information about their enrollment choices and the plan services. Beneficiaries sought information through several sources for information and advice during the transition to Cal MediConnect and afterwards as well. Examples of resources commonly used by beneficiaries include: providers; friends and family; group presentations; Health Care Options; community-based organizations; and the member services line for their new CMC plan. Many beneficiaries felt that it was extremely difficult to find the information and advice they needed. In contrast, a smaller minority felt that they didn't want any help navigating their healthcare plan, and that it was best that they serve as their own advocate.

*You know, I—I feel like I'm just out there without any support and who do I—I would love to have a solid person to go to. An advocate. You know, what do I do?*

*We can look for the information, we can find it ourselves. We do not need to call all the time. We can flip through the book and look for what we want. Especially that there was this switch to CMC, everything is different from what it used to call HPO... no, HMO. Available doctors are different. We cannot get the needed information. The book is still useful. We can rely on ourselves as long as we have the book.*

**Calling Health Care Options:** During the enrollment process, most beneficiaries remembered that there had been a phone number listed on the notification letter where they could call to get more information about CMC. Many reported that they did call Health Care Options (the enrollment broker for DHCS). Typically, respondents described calling Health Care Options in order to understand what they were being asked to do and what their options were. Most who called HCO seemed satisfied with the service and said they received the information they needed. Some also followed up by calling their doctor or calling the specific plans to get more information.

*Well, I called the 800 number that was sent to me in the—and, and she was very cordial and explained it to me ... And—but I wasn't happy with the whole thing.*

*I spoke to the workers from the program and they helped me decide what to choose. I called the number that was in the letter I got. I felt I had enough information to make a decision.*

*Well, the important information on Medi-Cal/Medicare stating [reading from a written document] that Medi-Cal benefits were changing and that I had enrolled in Medi-Cal managed*

care plan to receive my Medi-Cal services including Long-Term Services and Supports. The reason for this change was to help Medi-Cal services work better—work better together. So I called, um, um, who did I call? The options department?... That—that was from the letter that I got from the Health Care Option. And they—they listed a lot of health—health care insurances. So I called most of 'em. And then they—they—had Cal—[CMC health plan]. But then, um, I didn't—I didn't go for that yet until I talked to my doctor.

**Moderator:** So who else made a phone call like [beneficiary who called Health Care Options]? One, two, three, four, five of you. And, um, eh—that, that—did you feel that that person or that uh, person was able to help you—give you the information that you needed? **Beneficiary:** Yup. Yeah. **Another beneficiary:** More or less.

**Seeking information from community-based organizations:** Beneficiaries who had pre-existing relationships with community-based organizations and advocates relied on these relationships to make decisions about Cal MediConnect, as opposed to Health Care Options or the member services line. Many beneficiaries described having a “case manager” or advocate from an outside organization.

*[My case manager] is at the psychiatrist center. This is the mental health facility. Uh, they have a psychiatrist on staff there. And, um, they—they help as far as, uh, my medications. As far as uh, changin' where your health—workin' with me with insurance. Any forms of insurance help, she'll work with me with that, too. Doesn't work for [CMC health plan]. So, this is the person who's helped me as far as the insurance is concerned.*

*Well, I had somebody help me. She's with HICAP. And so she advised me to opt out of it. It's a health insurance something—it helps people make decisions, kind of like what plan to go to.*

*... And for other health care issues like paperwork and stuff that comes down the line like, uh, you know, Cal MediConnect and what do I do with all this paperwork and stuff, I go to, uh, my advocate is the ... Center for Independent Living. And, you know, they have a whole crew of people there with their little specialties like healthcare, housing and so on and so forth. So if—if my general worker doesn't know, one of his co-workers does and he'll put me on to that.*

*Because I have In-Home Support Services I'm a part of an advocacy group, and that advocacy group, there's an organizer that runs it. She's awesome. And she's the one who told me about the Ombudsman. And when I called them, things actually did get taken care of.*

**Group presentations about Cal MediConnect:** Finally, a small minority of beneficiaries attended group presentations held in community based organizations or sat in on conference calls about the transition to Cal MediConnect. The beneficiaries who attended or called in to these meetings were pleased with the information they received.

*I listened in on the—telephone, I think, conference calls. Yes, he had some conference calls on the— Yeah, telephone. They have a telephone, you can listen on a telephone to— on those calls.*

*I actually attended .... They had actually, uh, training classes. They actually went around to senior centers.*

*They came here [senior center] to us and we had a workshop just like this and we could ask all the questions and they would answer the question I guess they was like you. She would ask you the question and you would answer for all of us like that. They came to us.—they came here and they stayed a half a day with us.*

**Calling Member Services:** Once enrolled in a CMC plan, calling “the number on the back of the card” seemed to be the most common approach for seeking information and advice among our focus group participants. This was also true of those who opted out or disenrolled, many of whom described calling the health plan in order to disenroll or to understand why they had been transitioned to Cal MediConnect. Most beneficiaries who called member services were very pleased that their questions were answered in an efficient manner by the member services staff person. Beneficiaries who were dissatisfied with their health plan’s members services line either felt that the representative speaking to them didn’t have sufficient knowledge of the health plan or that there was inadequate follow-up to their inquiry. In a few instances, the beneficiaries reported not being able to get through to their health plan member services.

*Yes, I called [member services] and asked what places can I go, because I didn’t know.*  
**Moderator:** *And did you get the information you would like to know?* **Beneficiary:** *Yeah, it was fine.*

*A lot of it depends on who you get on the phone. Sometimes you'll get a nice gal that is very helpful and the next time they just wanna go home.*

*So I called them and, uh, they just kept passing me to another person. I was on hold for hours. And then they disconnected me. And then I couldn't get back in. Every time I tried to call, it's like my number had been blocked.*

**Other information sources:** Less commonly, beneficiaries made decisions about enrollment or learned about the specific nature of their benefits through other media sources like the radio, or through a friend or family member.

*Yes, on the radio. I learned about it because they said we were doing lots of things there. They mentioned [Medicare Advantage plan], [CMC health plan], many of them, [another CMC health plan], many plans. And--and I asked at that number they gave out in the radio. I asked if I could enroll in [CMC health plan]. I chose this one because--well, my family friend was also in [CMC health plan] and so I stayed there.*

*I heard from a friend who had the same health insurance that [CMC health plan] had a Cal MediConnect plan. My friend thought this plan was much better so I wanted to switch. The plan she was formerly on was outside of [CMC health plan].*

### **Choosing or Changing Cal MediConnect Plans**

All beneficiaries were “passively assigned” to one Cal MediConnect plan in their county. They had the choice, however to opt out, disenroll, or change plans, which they were notified about through letters or

community presentations. While disenrolling was more common than changing plans, the focus groups explored why some beneficiaries chose one plan over another or why they switched plans.

**Reasons to choose a plan:** Most beneficiaries chose their CMC plan based on whether their current providers were in the plan's network. Many beneficiaries sought information specifically about which CMC plan would allow them to keep their providers, in most cases asking their providers if they would be accepting patients with Cal MediConnect. Keeping providers also appeared to be a significant factor in the decision to stay in a CMC plan or disenroll.

*But what happened is, um, right now it's [CMC health plan] when they changed over—and the reason I came with [CMC health plan] is because I wanted to stay with my county doctors, because in 2000 I had emergency spinal surgery so I wanted to stay with the people that knew my case. I didn't wanna go outside and start my issues—my history all over again. So I ask my primary care physician: who—in order for me to stay with her, who what insurance to go with. So she told me. I chose [CMC health plan].*

*So I had to ask the people that fix my wheelchair what plan can I get on and they would still fix my chair. Because this is what I—this is my livelihood. My wheelchair. So he told me to get on [CMC health plan].*

*First thing I did was call my primary physician and talk with the lady that handles all the paperwork and everything to find out if they were gonna be carrying the Medi-Cal Connect program. So I would still have the same doctors.*

*Well I have my doctor and, uh, I'm very confident of him. Uh, my main concern is if there is a change if, uh, he belongs to the group that I have the insurance so he does so I continues with him.*

*Well I talked to my doctor and I asked him which plan was he still—you know which one did he want... Which one was the best for me? Which one was best to keep him and the doctors that I had?*

*[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.*

A few mentioned that learning they had increased benefits or a larger provider network under a CMC plan influenced their decision about which plan to enroll in.

*They don't cover for the dentist.*

*...I didn't feel the need to ask anyone, I knew what I wanted right away, because of the mental health services offered. [CMC health plan] is more widely used in my vicinity. Many more doctors that I know take [CMC health plan]. [Another CMC health plan] is more of a closed system, I think.*

Beneficiaries described changing plans because their original plan fell short in some ways, including unsatisfactory providers, changes to coverage for prescriptions or medical equipment/supplies, perception that another plan offered better transportation, differences in dental coverage (some CMC plans offer increased dental benefits while others do not), or

increased out of pocket payments (usually because some service was no longer covered so they felt forced to pay for it out of pocket or received a bill for services).

*[CMC health plan] doesn't have as many choices as [another CMC health plan] does for one thing. Don't have as many doctors, they don't send you to so many different specialists.*

*They don't cover for the dentist.*

*—they sent me a paper, and I'm forgetful, I forgot they sent it and I didn't respond. So they gave me [CMC health plan #1]. And I experienced that for a year or so and I said, "This is horrible." I couldn't wait to get another letter so I could go back to [CMC health plan#2]. And I won't leave it again!*

Some beneficiaries were assigned to a plan that was not their choice, so they asked to be switched.

*They did try to put me in a plan that I never went to. I don't know why they put me in this plan. I had always chosen [CMC health plan], so there was some confusion. I had to tell them [CMC health plan] numerous times. They did assign me to a doctor with a different health plan, every now and then I'd be charged something and receive a bill and then I'd have to call the billing office of the other plan and be on hold and that was kind of a hassle. I'd have to verify that I didn't receive the services.*

### **Beneficiaries' Suggestions for Improving the Enrollment Process**

Beneficiaries were asked specifically to offer suggestions for improving the CMC enrollment process. Overall, beneficiaries felt that the resources provided by the health plan were overwhelming (there were too many pages or the information was confusing), but somewhat paradoxically that individuals weren't given enough information about their specific care. Many beneficiaries suggested simplifying the written materials or thought that the enrollment process should be slowed down. Though the first notices went out 90 days before enrollment, some described having health issues during that time and wished the deadline had been extended. Others missed the earliest mailed notices and didn't learn until it was too late. Many expressed an interest in having individual counseling to help them navigate the enrollment process. Group presentations at community-based organizations were agreed upon as a good way to convey complex information about the plans.

*I never received any information, but a meeting could explain this to me.*

*And I would like somebody to work with me to choose my primary doctor. That would be good... weigh the pro and cons, you know, that would help..., how expensive they are, um, how, you know. You want to know that.*

*The paperwork. When you get all the paper in the mail, the great big book? And you get to readin' all these things and it gets you bungled in your mind. If they could just simplify it. So you need a doctor? Here's a list of doctors. But they send you like 50 pages and at the end of the 50 pages you got some doctors. And you're wonderin—you gotta go back and find out what they're talkin' about like that. So it's just too much paperwork.*

*But the timing for us to enroll, from the time they sent the information, was like—Too little. Less than a month!...Yeah. There was not enough time for us to digest it and to think about it and to maybe talk to our doctors. They just told you, "By this date, you're gonna be enrolled."*

## KNOWLEDGE AND UNDERSTANDING OF CAL MEDICONNECT

The focus groups assessed beneficiaries' basic knowledge and understanding of the Cal MediConnect program. 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").

Early in the focus groups, beneficiaries were asked if they could define Cal MediConnect in their own words. The majority of focus groups beneficiaries had at least some misconceptions about the program, and few were able to describe the program in its entirety.

**Lack of understanding about what Cal MediConnect is:** Some focus group beneficiaries did not know what CMC was or how to describe it in their own words when asked.

*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.*

**Moderator:** *When I say "Cal MediConnect," describe that for me in your own words. What does that mean to you?*

**Beneficiary 1:** *Absolutely nothing.*

**Beneficiary 2:** *I was gonna ask YOU what it meant...I have no idea what Cal MediConnect means. [Laughter]*

**Moderator:** *Who agrees with that? "I have no idea what Cal MediConnect is."*  
*[moderator counting] One, two, three...*

**Confusion about different names and entities:** Overall, about 30% of beneficiaries had been members of the Medi-Cal managed care plan before the transition to Cal MediConnect, and many of these did not perceive any changes to their health insurance after the switch to CMC because the name of the plan remained the same.

*It's the same thing I had before, as far as I know. [Medi-Cal Managed Care plan name].*

Especially for those who had been familiar with the Medi-Cal managed care plan before the switch to Cal Medi-Connect, there was often misunderstanding about the difference between the Medi-Cal managed care plan, the "product" name for Cal MediConnect (Duals Choice/Duals Options), and the term "Cal MediConnect".

*I used to have [Medi-Cal Managed Care plan] and I didn't know how to transition to Cal MediConnect. But they told me that it's automatically enrolled to Cal MediConnect. There is something I don't understand though. Is the name [CMC plan name] one name but two departments? The company address is the same and I'm confused.*

### Accurate Understanding of Cal MediConnect

About a quarter of focus group participants were able to describe the Cal MediConnect program somewhat accurately. In particular, these beneficiaries seemed to understand that Medi-Cal and Medicare were being put together under one umbrella.



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

*It's the company that has taken, um, over people that have Medicare/Medi-Cal to be the management company to convert them into an HMO plan. Is that what it is?*

*Managed care company for Medicare/Medi-Cal.*

*I just received it as a merger of the two. Like, they were merging together and they opened or they set up, um, health care areas that take both of 'em.*

*Cal MediConnect took our Medicare ... and our Medi-Cal. They put together, formed it in one place.*

*Well [CMC product name] is Medicare-Medi-Cal.*

**CMC is Obamacare, another health care company or an HMO:** When asked to describe in their own words what Cal MediConnect was, many described it more vaguely as “another company,” an HMO or Obamacare. Some seemed unsure whether they still had Medicare under the program.

*It's a Obamacare.*

*I think it's just uh, uh, another insurance company that's covering our—our drugs coverage and uh, uh, medical services, uh connected with [Medi-Cal Managed Care Plan name]. It's just another uh, company.*

*I understand there it's a, uh, HMO that covers everything.*

*Um, this is how I perceived it: um, Medi-Cal Connect was to give up your Medicare to an HMO and let them do all of your medical under one roof, one cap—as you wanna call it. Um, so therefore you wouldn't have Medicare any longer. You would just have that one HMO and they would take care of everything under one roof.*

Some beneficiaries understood that it was a new program that was intended to help the two different kinds of health insurance, Medi-Cal and Medicare, work better together and be more coordinated. Many stated that they learned this from the notification materials.

*Well I just—pretty much what they said it's that—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, um, like they said. One um—place that you go or one group to choose from. Something like that.*

*Well, if I need a specialist, eh, Cal MediConnect will direct me where to go or how to go. And they will approve, uh, or disapprove the—the services. So, in essence, by experience I think the organization is going in the right direction because they are oriented to not duplicate the services or to get to the right, eh, to the right doctor for—for instance—Medi-Cal Connect will make sure that I don't see a knee doctor when I need an eye doctor.*

*But with the new MediConnect thing, I think, uh, the state—[is] coordinating with your health carrier to see if...—the two, uh, entities combined can probably stay on top and have a better outlook on the patients, uh, being and so forth.*

*But, to me I'm just—I would probably, I would probably be wrong explaining it like this, but I would just think that they're trying to just manage everything to just one set—I don't know. I don't really know how to explain it. But like, put you in—in a plan where they can take care of everything in this one box instead of—well, I don't know.*

*... it's basically California has a program where they connect different types of HMO to get the best service to get all of the plans together and connect you with ... your doctors or whatever.*

## Main Unanswered Questions and Areas of Confusion

Focus group data was very useful in identifying key areas where beneficiaries had unanswered questions or misconceptions about the Cal MediConnect program. Most of these questions could easily be answered in more comprehensive notification materials. The most common questions/misconceptions were as follows:<sup>†††</sup>

- Many beneficiaries simply wanted to know more about why this program was implemented and who started it (e.g., *Is this Obamacare?*).
- The most common question after being notified was whether or not they could keep their specialists and medications.
- Many had misconceptions about opting out. Some were unaware that they had the option to opt out from CMC. Some who did know that they could opt out were unclear about what they would opt out of. Some felt that to “opt out” meant that they would lose Medicare or be without health insurance completely.
- Once in Cal MediConnect, some beneficiaries were unclear about whether they still had Medicare or Medi-Cal (e.g., *Do I still have Medi-Cal?*).
- There was often a lack of awareness of 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.
- Many beneficiaries had questions about their coverage, their benefits, or the availability of key services including: dental care, transportation services (e.g., *How far will they take you on the rides?*), coverage for alternative treatments such as acupuncture, or covering gym memberships.
- There were many questions about long-term services and supports in general. When the moderator asked about LTSS services, many beneficiaries wanted to know how they could find out more about LTSS that might be available.
- There were many questions specifically about In-Home Supportive Services. Those who didn't have it often asked how a person could get qualified, and some who had IHSS

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<sup>†††</sup> Most of the misconceptions listed are addressed in more detail in other sections.

already had questions about whether recent changes in hours were due to the Cal MediConnect program.

- Some beneficiaries lacked awareness of the health plan Member Services phone assistance. They did not understand when or why they should call the phone number on the back of their insurance card.
- Some CMC beneficiaries had questions about whether they would still be covered for medical care if they traveled out of the county, out of the state or out of the country. They were concerned that they would have to pay out of pocket if they had a medical issue when visiting relatives. This was of particular concern to beneficiaries who were immigrants.
- There were many beneficiaries who had questions about coverage for behavioral health services. These were often beneficiaries who felt they needed mental health services but had not used them before, including whether they would be eligible for therapy or group services and what might be available for addiction treatment.
- There were questions about care coordination benefits. Specifically, those who did not have it often asked how to get services (e.g., *How do you get a social worker?*).
- Many beneficiaries had questions about why so many doctors were not taking Cal MediConnect (*Why aren't the doctors who we currently have joining Cal MediConnect? What's keeping them from joining?*).

## CARE COORDINATION IN CAL MEDICONNECT

The new care coordination benefit is often the most prominent aspect of Cal MediConnect for beneficiaries who receive it. At least 23% of focus group participants said that they received care coordination from the plan.

***Moderator:** Um, when I say "Cal MediConnect" what comes to mind? What do you first think of? **Beneficiary:** A coordinator.*

### Awareness of Care Coordination and Care Coordinators

Since care coordination is a new benefit provided to some CMC enrollees, focus groups explored beneficiaries' awareness of this program and, for those who received it, what they called it. Some beneficiaries were aware of care coordination offered by their health plans, but most were not. For those aware, care coordinators were described by beneficiaries in a number of ways. "Social worker" and "care manager" were the most common terms used. Some beneficiaries also used "nurse," "case manager," "somebody from the plan," "counselor," "[CMC health plan] lady," and "case worker." Some of these terms were also used to describe care coordinators or people from the plans conducting HRAs, or social workers from IHSS who came to conduct their yearly assessment.

It was clear throughout several focus groups that many beneficiaries did not know about the availability of care coordination before the focus group. Once the service was mentioned in the group, many beneficiaries asked how they could go about finding one.

***Moderator:** [Other participant] mentioned a person named a case manager. Do you know if you have one? Have you ever been told about that? **Beneficiary:** No I have not.*

*I want to ask you, uh, how do you get a social worker?*

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

Many beneficiaries talked about the need for additional support and expressed feelings of isolation as they navigated through multiple systems and providers.

*You know, I—I feel like I'm just out there without any support and who do I—I would love to have a solid person to go to. An advocate. You know, what do I do?*

*—I didn't know that I could talk to somebody about my care that I'm getting and see if I can change it. Cause once I feel I'm unsupported I kind of shut down.*

### High Satisfaction with Care Coordination in Cal MediConnect

Many beneficiaries who received care coordination from their CMC health plan expressed great satisfaction with services provided from the care coordinators. Care coordinators were seen as key individuals who were involved in all aspects of care, as problem solvers, and as the go-to person for questions. Beneficiaries described their care coordinators as organized, responsive, proactive, and helpful in identifying areas that may need medical attention. Communication from

care coordinators varied, with some beneficiaries reporting multiple calls a week and others being called monthly or less.

*Well in my case, with the [CMC health plan], I'm very happy. And the reason is, they even have a social worker and the social worker will call and they ask for the needs. She's very assisting. A tremendous human being. And she will try to solve, uh, whatever problem you have. And that is something that we have to commend from [CMC health plan]. The social worker, I think, I forgot to mention that, but the social worker, I think, is the one that has the key for everything.*

*I think I have one. Because they do call me every so often and check and see how I'm doing. And that is—That is your go-to person cause they make it happen.*

*She is a lady dealing with Chinese customers in [CMC health plan]. Whenever you call, she takes care of things and provides solutions.*

### Care Coordinators Facilitate Access to Medical Care and LTSS

**Care coordinators educate beneficiaries about services available through CMC:** For many beneficiaries who had care coordinators, these coordinators were a primary source of information about services they were qualified for and new services that were available through CMC. Many described how they didn't really understand the CMC program until their care coordinator explained it to them. Overall, beneficiaries with a care coordinator seemed more satisfied with Cal MediConnect, not just because of the care coordinator, but because they were more informed about the additional services CMC could provide.

*And then—and then after when I got the letter on, uh, my transportation and stuff like that, they—they sent somebody to my house and they explained to me what, uh, this and that.*

*Um, I had a lady from [CMC health plan] come out. ... maybe it was because I was disabled or whatever, but I had a lady come out. And she was from [CMC health plan], and she just wrote down basically what you guys are doin'. What the services like have and all this ...,*

**Care Coordinators help facilitate access to LTSS:** One reason that some beneficiaries were satisfied with care coordination was because the care coordinators had facilitated access to additional services that had made a major impact on their lives. In-Home Supportive Services and transportation were the most common services that beneficiaries mentioned were set up for them by care coordinators. One beneficiary who was a family caregiver mentioned that the coordinator got her connected to CBAS (adult day health care).

*The in-home services... [In-Home Supportive Services] was, uh, that is a benefit that we didn't know all these years but uh, [the care coordinator] is the one that informed all the benefits available. That is, that's new. We didn't know. We know now!*

*Well yeah, I can say something positive, actually! So the case manager that called last one, he, uh, he actually—I told him my problems with transportation service through, uh, Medi-Cal Connect and he said maybe he could help figure that out. So he sent me the*

*paperwork again, uh, he didn't think you had to sign up but he sent me some kind of paperwork in the mail. So maybe there is some kind of work around I just need some...kind of person to help me.*

*I think my, uh, case manager, um, I think she's the one that told me about the [CBAS] program. And, so then, I called them up and talked to them and they talked to me and we—we been communicating so we can get this going, so I'm gonna go on, uh, the 29th.*

**Care coordinators increase access to medical care:** Care coordinators played a critical role in connecting beneficiaries to specialists, finding providers who would accept their insurance, and making appointments.

*[My care coordinator] brought paperwork, let me know what, group [provider] is in and how they're supposed to help me. They gave me a phone that only has the important numbers for people that need to be contacted if something happens and um, all the case managers and stuff in it from [CMC health plan]. And—and I had two referrals that were just...either too far or they don't accept more patients or there's just a problem. And that case manager—for a week, or two weeks—she worked—worked ...to find the right person for me that was closer to, you know, accept me and stuff like that. And finally, one of them I finally got an appointment.*

**Care coordinators help beneficiaries avoid the Emergency Department:** In at least one case, a beneficiary described how his case manager was able to assess his pain and provide home visits for pain shots that allowed him to avoid going to the emergency department (ED).

*I have a case manager. So the case manager calls me at least maybe three, four times a week. So my case manager makes sure I have everything I need. He even organized a way for me to—when I'm in, like, um, on a scale of one to ten on a ten during pain he has—uh—set up a company to come instead of me going to the emergency room. They come out and give me a pain shot.*

**Other care coordination services:** In addition to helping them access new services or get referrals, many beneficiaries reported their care coordinators helping them with other things, including:

- Assess their pain level over the phone
- Send providers for home visits to help the beneficiary avoid ED visits
- Reminders to take medications or pick up prescriptions
- Check in with the beneficiary about whether they are sick or have a problem
- Emotional support
- Answering any questions about health coverage or benefits

*Oh I didn't—I didn't pick up the prescription... and he told me I need to go to the drugstore and pick it up cause I need to takes it. That was last week. And then he'll send me a letter, uh, then tell me he been trying to get in touch with me and for me to call him.*

## Care Coordination: No Impact, Unavailable, or Not Helpful

While many beneficiaries receiving care coordination reported satisfactory experiences, others found care coordination to have little impact on their well-being, or they felt these services were unavailable and health plans unresponsive to requests for help. In one example, a beneficiary who received monthly calls from her care coordinator didn't find those calls helpful.

*I asked her, "besides what you're doing, uh, in what other way can I benefit from the services that you provide for my illness?" She says, "it's just that you can call me at any moment you have an illness problem. If you have a fever, blah, blah, blah, blah." And I say, "look, I appreciate your attention, but if ... I ever have a medical problem, I go to the hospital. I'm sorry, but I'm not going to call you." And since the second call was also a routine, I didn't answer.*

*She calls me and she leaves me a message. She says, "I am calling to remind you that you must take your medicines as they were prescribed--written at the indicated times by your doctor." She earns--she earns her wage, no?*

There were instances where beneficiaries did not receive the help they needed from their care coordinators or did not understand their responses, such as explanations for referrals and waiting periods for DME or services. In these instances, beneficiaries were frustrated because the care coordinator did not help them speed up the authorization process or prevent a delay in services. In one instance, a beneficiary called the ombudsman to help when her care coordinator did not.

*I went to a specialist and everything and they said I don't need two pairs of glasses, so all I have is reading glasses ... I have a care—what you call it? A care manager. I have one. She called me all the time. And she still said "Oh, you gotta wait two years." Why I have to wait two years? I don't understand.*

*And I just got approved to get a new prosthetic leg. I'd had this one for two years. I had to go emergency room because it started bleeding. And it is the prosthetic leg. I'm like, why's—what's takin' y'all so long? I don't want to be stuck in no wheelchair no more. I was in a wheelchair for three years. ... I talked to my, my case manager. She said "we workin' on it" and—but—you workin' on it ... that's not the answer I wanna hear. You know?*

*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. Over the physical therapy.*

## Attitudes Towards Health Risk Assessments

Health plans are required to conduct a health risk assessment (HRA) with beneficiaries as a first step toward identifying individuals who need care management or who have unmet needs. Many CMC health plans hire other companies (i.e., vendors) who send HRAs to beneficiaries through the mail or call beneficiaries on the telephone. Most focus groups beneficiaries did not recognize the term "health risk assessment" but instead talked about interviews and surveys, often sent by health plans or other agencies. Once the focus group moderator described the HRA, the majority

of beneficiaries had negative attitudes toward them. They reported that they found the HRA annoying, especially the health plan's persistence in having them completed. Often, beneficiaries did not recognize that the HRA was coming from the CMC health plan because the plan had hired another agency to conduct the survey.

**Beneficiary 9:** *I hate that thing.*

**Beneficiary 2:** *I do too!*

**Beneficiary 9:** *And then they harass you...*

**Beneficiary 2:** *I hate it.*

**Moderator:** *And you hate it?*

**Beneficiary 2:** *I hate it.*

**Beneficiary 9:** *Hate it.*

Some beneficiaries who completed the HRA did not see a correlation between their answers and any improvement in their care or changes in services. Others mentioned that the questions asked during the HRA did not seem applicable to their particular health needs. Many beneficiaries mentioned that they received the HRA survey but they neglected to fill them out.

*Here it comes all the time. I mean it's like, inundated with paperwork and nothing happens. It's just—what's it for?*

*It's geared—it's geared to mental health. I always tell them. They always ask you, "Are you depressed?" This, this, this—I tell 'em, I have medical issues. I'm not depressed. So they really need the—make a questionnaire to everybody. Everything. The same thing. I'm not depressed.*

*You know I think I was sent that but I neglected it.*

### **Individualized Care Plan**

An individualized care plan is a plan that summarizes the beneficiary's care needs. The ICP should ideally be based on the beneficiary's answers to the HRA and their health record. Many beneficiaries reported getting surveys in the mail, but few remembered getting an Individualized Care Plan. Those who did remember getting an ICP were typically not impressed by the information that was listed.

*Did you ever receive kind of an individualized plan, a customized plan that gave you a list of all of your medications, a list of instructions, a list of the doctors that you had to see? **Beneficiary:** Yeah. They have that ....Yes. I receive one all the time about the—the medicine the—the medicine, uh, coordination and the programs they have.*

*It comes in the mail constantly!... Always comes in the individualized paper. We wanna do this for you, yadda yadda yadda. Zero. Like talkin' to the wall.*

### **Communication and Coordination in Cal MediConnect Plans**

One of the main objectives of Cal MediConnect is better coordination and streamlining of services across different providers. Not surprisingly, the extent to which Cal MediConnect has been able to achieve this coordination, from the level of the health plan down to the individual



beneficiaries, was a major topic of conversation across all of our focus groups. Usually when beneficiaries were talking about their perceptions of coordination, they began by talking about the changes in the level of communication they were seeing between different parties (beneficiary, CMC plan, providers). Thus, in focus group analysis, communication became a proxy for perceived coordination.

**Communication between plan and beneficiary:** Beneficiaries describe their experiences communicating directly with representatives from their health plan both at the time of the transition or afterwards. Often their experiences communicating with the health plan set the tone for their overall satisfaction or dissatisfaction with the plan. Several beneficiaries reported that they were satisfied with the help they received when they called their health plan, and these individuals were generally happy with their Cal MediConnect plans.

*What I have noticed is that since we have had [CMC health plan], uh, there is more communication with them. More—more focus. They are constantly contacting one, as the—as the woman said, to see the people's needs. They're constantly interviewing us.*

*I think they're getting better. I do. I feel like everything is just, like you can just call this one number and they just handle everything. And that's kind of the simplicity of what, I guess, they're tryin' to do.*

Fewer beneficiaries reported that they were very unhappy with the assistance they received when they called health plans. Some even reported feeling that “the buck was being passed” or that they had been “given the runaround.” This engendered feelings of dissatisfaction and mistrust toward the health plan overall.

*What happens is, like, ok, uh, I experienced this, uh, I called up ... cause when they sent the stuff out and I read it, I didn't understand some of it, so I called them up. Well, it seems like one hand doesn't know what the other one's doing. You know? Like, you talk to this one person, ok. And then you—they say, "well, I'll refer you to somebody else." And that day I went through 10 people and finally, I said, "I've had it!" I'm hanging up, because I wanna kill somebody. It made me crazy! I mean, I had one simple question. How—how did I have to go through 10 people to get an answer and I didn't get the answer yet? Why? And I think that's because they were in such a hurry to get this going, they didn't think about all the things would happen. You know?*

**Communication between plan and providers:** Another proxy for beneficiaries' perception of coordination was how well the health plans are working with their individual providers. Many beneficiaries alluded to or explicitly described poor communication between the health plans and various providers. Many felt that providers weren't given enough information about the transition to Cal MediConnect, and many felt that their doctors did not have sufficient knowledge of the plans themselves (specifically, what services and drugs are covered, the referrals process, etc.). Many beneficiaries attributed disruptions in their care during and after the transition to seemingly poor communication between the plans and providers.

*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. ...If you have a problem with the bill they will not call your doctor. They're not allowed—customer service, because they're not claims, but then you can talk to claims to get a copy of your bill to them so your bill can be taken care of.*

*Uh...well, communication within their own organizations and—and—and the doctors and the organizations that they're working with. I've asked them. I've reached out to them for help...—why can't they call and coordinate with the people they say I'm covered with? If they're covering me through this pharmacy, then why aren't they communicating with this pharmacy and saying, "Hey, [she] needs this. Make it happen, this is her insurance. Bill this." So...why is it such a problem?*

*See [the doctors] weren't notified. My doctor had no idea about it until I showed him the letter.*

**Coordination between different providers:** Beneficiaries were asked whether they felt that their care was more or less coordinated after the transition to Cal MediConnect. Most beneficiaries reported better coordination between providers after the transition, especially in the area of information exchange and access to their medical records across sites. They often mentioned that since Cal MediConnect, one provider tends to know what happened when they visited another other provider without the beneficiary having to tell them. Most of the comments from beneficiaries about poor communication between providers had to do with referrals and authorizations (see section on referrals and authorizations, page 47).

*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.*

*[Before CMC] I had to inform [doctors] exactly what was happening. And not now. Everything is through the computer. They just enter it in the computer and they start to—"ah, you have this, you have this other thing, you have this other thing." There's no need for so much paperwork. The advantage that it has is that one avoids a lot of questions that maybe one doesn't even remember one of the questions.*

*I just know that like, I'll go to my specialist—to see my specialist—and they take care of connecting with my primary doctor to get my referral, and then I just get a letter in the mail saying, "Here's your referral from this month to—this month you have to go to your—" and I hadn't done anything. I don't have to get on a phone and make that happen. They make it happen for me.*

## MEDICAL CARE IN CAL MEDICCONNECT

### Primary Care

Primary care was an important topic in the focus groups. The majority of focus group participants rated their health as fair or poor, and rely on medical care. Most beneficiaries (96%) had been to a primary care provider (PCP) at least once since switching to CMC, and 49% had been to a PCP three or more times in the last six months.

**Primary Care Continuity:** For most beneficiaries, being able to stay with the same PCP was very important to them after the CMC transition. When possible, DHCS auto assigned beneficiaries to plans that included their previous PCP, but this was not always possible if the PCP did not participate in the plan network. Beneficiaries who were able to keep their same doctor were often the most satisfied with the plan, and vice versa. Most beneficiaries had very specific reasons for not wanting to change doctors. The most commonly cited reason for wanting to keep their same PCP was that they had a relationship with that doctor, or they communicated well and felt they were getting good quality care from that PCP. Some were reticent to change primary care doctors because they believed it would change all of their authorizations for specialists and other services. Others were motivated to keep their doctor because the provider's office was nearby and they feared having to travel further.

*I fell through the cracks a couple of times, and the reason I don't change, uh, my primary is because ... she's very good. Me and her communicate very well.*

*The thing is that—my [medical] file is this big. Because [PCP] been seeing me for 14 years... And I say, if I go to another doctor they going to start from the beginning!*

*It takes—so you can always change your doctor, but it takes until the beginning of the next calendar month. And then every single authorization or any specialist you're seeing? All of that has to be re-done. So I have a number of specialists. So it's really a pain to change your doctor!*

As noted in the section on satisfaction, one of the main factors contributing to beneficiaries' satisfaction with CMC was when they were able to stay with the same primary care doctor they had before the switch.

*I'll [rate the CMC plan] a ten [out of 10]... cause I have the same psych—same doc—um, primary care doctor—specialist as I had [before] so that was...I really like my doctors.*

Alternatively, when beneficiaries had to change PCPs, often leaving a provider with whom they had a longstanding relationship, this was a main factor that contributed to dissatisfaction with CMC. Many people expressed dissatisfaction with their new doctor and felt they were not getting good quality of care or did not have the same level of relationship. That dissatisfaction seemed to spill over into how they felt about the CMC program overall.

*Here it's almost like the doctors are place markers. And I just go in and like, okay this is the prescription I need. This is what's going on. But I basically just tell them what I need and, um, I have to do the research for myself. They're not really consultants.*

*I feel better with my—my original doctor that I had. So I—I'm not pleased with the doctor I'm seeing now...*

*The medical part is the one I don't like because it is not the same doctor and there is no longer the same trust with talking to the doctor.*

**Primary care access:** When beneficiaries' PCP did not participate in the CMC network, the beneficiary was assigned to a new PCP or could choose a new one. Some beneficiaries reported having a difficult time finding a new PCP they liked because many of the doctors in the new CMC network were not accepting new patients.

*Um since—since they changed my insurance I'm no longer able to see my—my regular doctor because they don't accept that insurance. And then they put me on [CMC health plan], uh, um, and they sent me a book of listed physicians in a book where I had to find another doctor and almost every doctor on there were not accepting new patients.*

*I had to change doctors, um, where, um, the clinic I was going—didn't accept [either CMC health plan]. And, uh, so I had to find a new doctor. I'm not happy with the doctor, um, but that's the only one that I could find that would take it.*

*I can't go back to where I was because of they'd never accept the insurance. If I could find one that would actually take the insurance I would [change doctors], but when they sent me with [CMC health plan] every doctor was no longer taking any new patients.*

In terms of access to care and wait times, most beneficiaries said that the switch to CMC did not appreciably change the amount of time it took to schedule an appointment or to wait in the waiting room for a PCP. In instances where some beneficiaries were not able to get an appointment with their PCP in a timely manner, they were scheduled to see another physician in the same practice, a nurse practitioner, or physician's assistant. This was often confusing and not ideal for beneficiaries.

*I have a question. What I see is that in the CMC card, they designate a doctor for you, but you don't even know that doctor. Because every time whoever else helps you, another person, except your doctor. Well, in our case, that's what has happened. Until now that my mom is very, very sick, we met the doctor. We didn't know him. So anyone can help you. Another doctor—*

*I have to usually sometimes see his assistant. Because he's always booked or somewhere else. Uh, I didn't like it because I have to open up and feel comfortable and he doesn't know my problems. And when I see him I have to say it over again.*

*The doctor that's on my health insurance card is—is too busy with other patients to see me ever. And they told me that after they switched me to that doctor, not before. And so I have just a physician's assistant that I see to get all of my primary care needs met.*

For the most part, beneficiaries reported that out-of-pocket payments for primary care either stayed the same (no copay) or went down (no copay any longer) after changing to CMC.

*You have no cost to see the doctor. It is free now. So before it was copay. Right, so that's a plus.*

**Assignment of primary care/switching providers:** A few beneficiaries knew about the right to switch providers, but for the most part, many beneficiaries learned of this right during the focus group discussion. Many felt better about their autonomy after they learned that they were not limited to the PCP who was listed on their card.

*Well now I know. I can [switch PCP], right? Well I thought I was stuck with him. And it's my own shortness of thinking. Um, but I never knew that I had a choice. Let me put it that way. And it's good to know. You know. —I feel less restricted. And, and I know that I have, uh, I can choose. You know, yeah.*

*I didn't know that. I didn't know I could [switch doctors], but I'm gonna look into it now.*

## Specialty Care

Specialty care is an important service for dually eligible beneficiaries. Among the focus group participants, 83% had seen a specialist in the last six months, and 40% had seen a specialist at least three times during that time.

**Continuity of specialty care:** As with primary care, continuing to see the same specialist was important to beneficiaries. Those who were able to keep seeing their specialist noted this as a point of satisfaction with CMC. Beneficiaries who were not able to continue with the same specialists, particularly those who had longstanding relationships with one or more specialists, were often very upset about making this change. Many beneficiaries described doing a lot of work to get themselves to the specialists they had before CMC, and they saw the switch to CMC as starting over.

*...it was difficult to be able to see different doctors or even find a doctor that was covered up under the insurances. That was a nightmare because it took me about like, five years, to try to even get to this point where it's like right now I get to see all kinds of specialists, orthopedics, mental health, get my prescription.*

*I had to switch my—I haven't switched. I have to find a doctor that accepts this insurance—my gynecologist, the one for the feet, and for my blood pressure. It's very problematic.*

Beneficiaries who were undergoing treatment for serious illness during the transition found the change of specialists under CMC particularly problematic. One beneficiary who had been undergoing treatment for cancer for several years was particularly upset that she was not allowed to continue with her previous provider.

*But if your referral gets denied. If your referral gets denied and [cancer center] was treating you like they were doing with me—now with [CMC health plan], I got a denial in the mail that my group is denying that I continue my cancer treatment with [cancer center]. So that's huge.*

*Access to specialty care in CMC:* A few beneficiaries mentioned that there were not enough in-network specialists in one or more of the CMC plans in their county.

*And so it's like, little things like when it comes to finding a specialist. And, um, that's very complicated and, um, most of the ...the doctors they referred me to did not accept the Medicare/Medi-Cal. So it was a bunch of drama.*

*Psychiatry, psychology, um, like I said...physical therapy or orthopedics... Too many people that need it and I don't think they have enough people that are providing it.*

*[CMC health plan] doesn't have as many choices as [another CMC health plan] does for one thing. Don't have as many doctors, they don't send you to so many different specialists.*

Another very common barrier to access was the geographic location of new CMC providers. Many beneficiaries mentioned that their new providers were located too far away from where they lived. After originally being sent to a doctor too far away, some beneficiaries did report that they were able to find doctors closer to them.

*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.*

*The doctor that I have, um, she sees me maybe, what, two—three times. Sees me once every three months, right? And then, uh, I have to go get my blood work done elsewhere, and it makes it very hard for myself because sometimes I don't have a ride. And then before, they changed me to this doctor--that doctor, my doctor would send me to the closest place. And these people, you know, they don't even bother to ask, "Is this close for you?" or, "Is it not?" And it's real hard. And I have to go clear down, you know, on the other side of town to get my blood work done....*

*Yes, we changed to a doctor who is closer to us. Yes, closer to us. After we switched to this new plan, we were able to choose a doctor who is closer to us.*

Some beneficiaries said that the health plan had helped them to access specialty care because they helped them find specialists or recommended they see a specialist.

*...they helped me find my doctors.*

*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 sendin' 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 like I [rated the plan] a ten because I don't have no problem with that no more.*

*Well before—before I would go to the doctor and then the doctor said well "Oh you should see this doctor or that doctor." ... And so um, he would uh, say, "Maybe you need this or you need that." And I would have to do it myself. ... But now, all I have to do is*

*just call in. They cover everything for me I don't—and that's important to me because I don't have to go and search for this and search for that. They take care of all of my business—medical business.*

**Referrals and authorizations for specialty care:** Delays were the most common issue mentioned related to seeing specialists. These delays were caused by the requirement to be referred to a specialist by their PCP and to receive pre-authorization from the health plan. The timeliness of referrals varied for beneficiaries and was a factor influencing their overall satisfaction with the plan. Many beneficiaries were frustrated with the long delays in getting specialty care.

*Naw I'm talking about referrals like specialists, doctors, too. That's—now for referrals that's takin' longer we got this new thing than it was before. That's just it. I mean, before it was—it was real quick and now instead of just, I've been waiting three months for—for specialists and it's just not going through, you know?*

*I don't know if it's the plan or if it's the actual clinic I go to, but ...—everything my doctor asked for this year, I had a problem with the authorization. Like, literally every single thing. Chiropractor? Six months. I had to call the Omb—Ombudsman. Six months to get a chiropractor visit? By that time she had to prescribe me a muscle relaxer, uh, because—because the problem got worse. You can't just let something go for six months.*

*Uh, I have seen a change. Before, when they referred me to a specialist, uh, it wouldn't take longer than 3 months. Before, it wouldn't take 2 months, 3 months. Nowadays, up to 6 months. So, this is making me think ...how practical it is to be there, because ...I must see a specialist. And if they tell me in January but they'll see me in July...*

*And every time this happens they go through a process of getting it approved, and special permissions and all that, and like I said. 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.*

*Always--since I retired I have had this doctor. And now that the plans started--I managed my cards on my own, right? Ever since I earned them, I managed them on my own. I would go to whichever doctor I wanted, but it was always with this doctor. I have always had her....I can still see her but now I don't like it much. That's why I [rated the CMC plan] a 7, because she has to authorize now if I am going to the optometrist or if I'm going to the one for allergies or if I'm going--she has to order it first if she--if she agrees with me going there.*

*Where the heck is my physical therapy referral? I mean, I had to deal with the Ombudsman when the chiropractor failed to get to ever call me and the physical therapy.*

Some of these delays in referrals to see specialists seem to be related to poor communication between providers, poor follow-through by PCP or specialists, and lack of understanding of how the system works.

*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 the derma—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. For every correction that's made. And then the doctor says, "Oh, well, you don't actually have to come back in for an appointment for the dermatologist, the dermatologist can just put in a request." 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.*

*I been waiting and waiting for a specialist to the—the one specialist who's supposed to be referring me to the other specialist, they gonna call me right back and it's been over a month and I'm still waiting. And what if I had a bad heart or something like that? You know? So, to me it just seem like it's a little game everybody's passing the ball with that stuff.*

On the other hand, some beneficiaries feel that referrals and authorizations for specialists have been smooth and timely. These beneficiaries are often much more satisfied with their overall CMC experience.

*Well, that every time I—I have an appointment or that they send me to some doctor or some specialist, uh, they quickly send me the request. They did an operation for my vision and I turned out perfect.*

*You know...any type of service I seem to need—even my specialist—comes at a—a pretty good time, you know what I'm saying? I think that's due to my doctor. I mean there's things they can put in I think they call it "stat." Means "put a rush on it." Okay? And I see that pretty much to get anything I need first off I go through my primary doctor.*

*So I'm in on time and with my referrals. [CMC health plan] automatically send it to me when they know it's done expired. So I'm okay.*

*Well they'll be something I need like, I go to a special—they send me a letter or—stuff—doin' that to get—they take care. It's real good to me as far as he's concerned.*

*Yeah, cause it took a couple weeks before I could get the appointment [before CMC]. And now it's faster. It's faster, yeah.*

*Like now, before they didn't ask for these approvals for specialists. The doctor would just send it and you would go. And now, one has to ask for—the doctor gives you the reference and he sends it to the insurance and we have to wait for their approval. Well, at least in my experience, I have seen that with me they have worked very quickly.*

## Acute Care

The majority of beneficiaries who attended the focus groups rated their health as fair or poor. Many discussed the importance of being able to go to certain hospitals, and many had described using the emergency department recently. Hospitals and emergency department coverage were both very important for many beneficiaries.



**Acute care benefits and coverage:** Several beneficiaries said improved coverage of acute care (hospital and emergency department) was an advantage of belonging to a CMC health plan. Many reported that they had not had to pay any copays for using the emergency department (ED), staying in the hospital, or undergoing surgeries since switching to CMC. Two beneficiaries noted there was no copay for ED visits and hospital stays even when these occurred out-of-state.

*Well I—at first, they told me I had to switch ... And I was kind of leery about that cause I've always been kind of leery about managed care. So I did and, um, it worked out for me because of Cal MediConnect. [There are] no copays for hospitals or for specialists. I'm not paying anything now. I was before in [Medicare Advantage plan].*

*I've had several surgeries this past six months—seven months now. Never, never a penny I had to spend.*

Some beneficiaries had concerns about CMC acute care coverage. One beneficiary was concerned because under Cal MediConnect, as he understood it, ED visits would not be covered in China, where he frequently visits. He said when he had fee-for-service Medicare, these visits were covered. One person reported that her CMC plan did not cover an ED visit and she is receiving a bill from the hospital. As a result she is afraid to go to the ED. Another beneficiary said that some treatments in the hospital were not covered. One beneficiary felt her health plan sent her to a lower quality hospital.

*I was supposed to have my surgery done in, uh, [hospital name] and they kicked me down to [another hospital name]. So they took me out of the good hospital and gave me the referral for the good hospital and just gave me, like, the generic hospital.*

*I did have to go to the ER, uh, when I had those dental extractions, uh, because the dentist wouldn't call me back and it kept—I kept bleeding and bleeding and bleeding... and so they are not paying for it and I'm being harassed by—by [medical group name] for over \$1000 now... so I can't go to the ER, apparently. They're not covering ER visits. I don't understand that.*

**Delays/disruptions of surgeries:** A few beneficiaries (one of whom later disenrolled) said joining a CMC plan disrupted or delayed plans for surgery. Another opted out in part because of fear of disrupting an upcoming surgery.

*Yeah cause I have a surgery coming up. I can't get it till I get my referral and I been waiting almost a year ... I don't know if I'm gonna keep waiting. I wanna change, but I like [CMC health plan]. You know? I just like 'em. I don't wanna give 'em up.*

**Unnecessary use of emergency department:** A few beneficiaries noted that they had visited the ED specifically as a result of not being able to get timely authorization for specialty care or a prescription medication.

*I've been denied medical--been denied pills and ended up in the ER.*

*I mean, they gotta put their finger on every little thing and approve it. You know...well, like if I have to see a specialist... Uh, if I have to uh, uh, go to urgent care or—or emergency, uh, on uh, well a couple of times I just picked up the phone and called the*

*ambulance and went and let them worry about it... In other words you wanna let them, let them pay for it. You know if they wanna micromanage well they have to suffer too.*

In contrast, one beneficiary reported that his CMC plan helped him avoid visiting the ER by sending a nurse to his house to give him a pain shot when needed.

*I have a case manager. So the case manager calls me at least maybe three, four times a week. So my case manager makes sure I have everything I need. He even organized a way for me to—when I'm in, like, um, on a scale of one to ten on a ten during pain he has—uh—set up a company to come instead of me going to the emergency room. They come out and give me a pain shot.*

## Prescription Medications

Dually eligible beneficiaries tend to use a lot of prescription medications, and beneficiaries in our focus groups were no exception, with 50% taking 7 or more prescription medications. Maintaining access to those prescriptions was a top concern of many beneficiaries as they transitioned into Cal MediConnect.

**Prescription continuity:** Some people reported that they had to change their brand name medications to generic medications, and most seemed to believe that this was acceptable. In fact, many beneficiaries had been already using generic medication. Some beneficiaries reported that they had an easier time getting non-formulary medications covered in CMC than they had in fee-for-service Medicare.

*[On original] Medicare—whenever I needed some medication they would say it's not covered. And they would—still, after appeals, they would stick to their answer. But here [on CMC health plan], uh, they will listen to you and, um, they do approve whenever they can.*

*But they are very flexible, too. And we have to recognize—we have to go back to the primary care and tell them, "Doctor. This medicine is not working." The doctor will take the phone and they say, "They have to have this medicine."*

There were some cases, however, where medications a beneficiary had been using before the transition were no longer covered under Cal MediConnect. Some beneficiaries reported that they had tried multiple medications in the past to find a medication that worked for them, and this medication was not on the CMC plan's formulary. Often in these situations the beneficiary's PCP was able to get the CMC plan to authorize the original medication. Of course, for some beneficiaries, having to repeatedly go through this extra step of authorization was a burden. Notably, several beneficiaries had problems getting psychiatric medications, but most eventually got them approved. Several beneficiaries said that had an easier time getting off formulary medications approved in Cal MediConnect than they had in original Medicare. A few beneficiaries reported that they did have to change pharmacies, but this was not an area of concern.

*And the—the [specific medicine]—my doctor has to always renew it through the [CMC health plan] because it's not on their formula of what to give ... She said this time I got lucky. It's been approved until the first part of 2017. But then the doctor went ahead and*

*changed me to try something else new. Which it's not working. And every time this happens they go through a process of getting it approved, and special permissions...*

*Uh, I had—like, one of the times I had a problem with like she did getting one of my psych meds. Um, I had to wait for, uh, an approval from my doctor. It took forever. And I just got irritated.*

*I particularly have issues with one psychiatric medication, which isn't covered on the formulary anymore. The doctor had to write a letter stating why I need this medication. This is a hassle, because I've been taking this for a long time, and if I don't take it, I could get very sick. Sometimes it takes a long time to process the letter, etc. and sometimes there isn't enough time before the medication runs out."*

**Disruptions at time of transition:** A few beneficiaries reported disruptions in getting their medications during the transition to CMC. Many who reported problems getting medications after the transition also reported that these issues were resolved with time. Some were forced to make the choice about whether to pay out of pocket to get medications while they were waiting for an authorization to be resolved.

*Like I said, mine was just disruption in the beginning. Because like I already said I was already set up and then they took me off without me knowing ...I was in the middle of getting my medication. I needed my medication. I couldn't get it. I was back and forth on the phone with [CMC health plan]. They said I had to deal with Medicare specifically to get this medication that I needed covered right now ...—but other than that, I don't have a problem with 'em. I mean, I—I—I'm okay with the [CMC health plan]. I haven't had any problems with my medical care whatsoever. It was that disruption during the time when they did that switching.*

*I wanna go back to the prescription. This was very, very uh, crucial. Cause for people are on have heart, high blood pressure, psychiatric, blood thinners—and I'm mentioning that because there was problem with that with my son and my boyfriend. Those medicines people cannot be without for days. Okay? For my son, it was when I took it to the pharmacy it was a Thursday. I had to wait until Monday or pay out of pocket. Do you know how much some of those pills can be? One of them, they can go from \$25 to \$100. And you don't have the money to pay out of cash until all of this gets resolved. And the pharmacy won't give it to you.*

**Out-of-pocket expenses for medication:** Most beneficiaries reported paying the same or lower out-of-pocket costs for medications after the change to Cal MediConnect. A few reported paying significantly more. This was usually in the context of paying out of pocket for a medication that was no longer covered under CMC. A few people noted that the pharmacy did not always charge them the correct amount initially or seemed confused about billing. Some beneficiaries changed pharmacies for no copay, which they said is fine, but others prefer to stay with the same pharmacy. However, a few beneficiaries' copays increased. These beneficiaries seemed to take multiple medications.

*But you have to read all these things they send you in the mail so you know what to do... And—and you compare your medication which the ones that they say they pay for. If the*

*drug store charges you a copay you say, "Well no, but [CMC health plan] said this is for free." And they'll stop. Because they would charge me \$2 for one of my meds... so you just have to, you know, you gotta take care of business with this medical thing.*

*I'll give MediConnect that. It did take away the copays.*

*You know my copay's higher. I used to only pay like, two or three dollars a month and I would get 'em all. Now I have to pay—save for ten medicines, invest nineteen dollars and stuff. I have like eight or nine right now at uh, Rite Aid and they want \$8.40 just to get it.*

## **Durable Medical Equipment and Supplies**

Durable medical equipment (DME) includes things that beneficiaries purchase once and use over a long period of time, such as wheelchairs, walkers, oxygen machines, and blood-sugar monitors. Medical supplies include things that are usually used once and thrown away, such as incontinence supplies, blood sugar testing strips, or bandages. In the focus groups, 53% of beneficiaries were using DME and 44% were using medical supplies. Many CMC beneficiaries who used DME and supplies reported satisfaction with these services. In fact, several beneficiaries noted that their new health plan called them and specifically asked if they needed any additional equipment or supplies. When the topic was brought up in the focus groups, some beneficiaries who didn't have any equipment mentioned things that they needed but didn't know that they could get.

*I would like a scooter to be able to move. I haven't called [CMC health plan] about this and they have never asked me if want it. I have a hospital bed and I would like some mattress foam under my bed because it's too uncomfortable. I didn't know that they covered a scooter.*

**Equipment:** Some beneficiaries noted delays in getting equipment after transitioning to CMC, including hearing aids, braces, prostheses, and wheelchair repair. Delays of a few days were often caused by the necessity of switching DME providers. Some beneficiaries also faced a new requirement to drop off and pick up equipment themselves, whereas previously it was delivered. Others noted inconsistencies or decreases in coverage (only paying for one hearing aid) since switching to CMC.

*The only other thing with what we have now is for her hearing aid. They only pay for one every two years. And so, if you need two, which she does, they will only pay for one. And it's like, \$2000. You have to choose which ear you wanna hear out of!*

*I had an incident with my oxygen. I wasn't aware that they switched me from [previous DME provider] who previously provided my oxygenator, they didn't tell me about that until they came knocking at my door to collect the equipment. They collected the equipment on a Thursday and [new DME provider] delivered equipment on a Monday, I think. I called [CMC health plan] and explained it all to them -- I get stressed out easily, a little bit of a hassle and I didn't appreciate that. In the end I called Maria at the MD office, who sorted it all out. [CMC health plan] had me on hold, I had to talk to different people, and it was a real hassle, had to talk to all sorts of different people, wasn't good customer service, no one seemed to know or assure me of the benefit or the service*

*provider. I'm glad it was ultimately resolved, but if another situation like that arises I might consider disenrolling.*

**Medical supplies:** Beneficiaries who use medical supplies reported some delays in getting supplies, particularly when they first enrolled in CMC. A number of beneficiaries also were dissatisfied with the reduction in the amount of supplies they were receiving at one time, e.g., receiving a one-month supply instead of a three-month supply as they had previously. Delays in getting supplies caused some beneficiaries to have to pay out of pocket for supplies while they waited for their supplies to be sent. Most were satisfied with the new system of getting their supplies sent through the mail, though some experienced delays getting the mail order system set up for the first time.

*...they won't let me go to the pharmacy to pick up my test strips anymore. I have to have mail order and again this flip-flop of, "It's this person it's—it's this ...this person is responsible. Everybody else is responsible."*

*And I ended up having to pay for my own test strips, which is incredibly expensive. I can't afford it. I am disabled. I'm on disability. And, um, I had to wait almost two months for them to fill that prescription to get those sent to me. It was outrageous. And I was—am—you know, my blood sugars were worse because of the stress involved. So they—instead of health care, they were causing me more health problems. Across the board.*

*[Re: incontinence supplies] They'll give you four or five [adult diapers] per day. Well, when you go [have a bowel movement] 15 times a day, you have to have more. Yeah. And it's very, I mean, it's very painful. ...Think about it.*

## **Medical Groups**

For some beneficiaries, especially those in southern California, medical care and responsibility for service authorization are delegated from the plan to a medical group. While focus group participants mentioned medical groups infrequently, a few felt that having a medical group created an extra layer of authorization, resulting in delays. One was confused about the relationship between the medical group and the health plan. Another heard from his doctor that they had to join a medical group to be a provider for the CMC plan and that the medical group was given power over his care.

*I will tell you what's happening. There is an existing problem with doctors now too that didn't exist before. Now some doctors have been forced to join some groups. Like, where I go there's that group—[medical group name]. Do you understand how it is? They forced him to choose a group. Because I talked to them in the beginning. I said, "Are you going to quit or something?" I have been with that doctor many years too. Anyway, he told me, "It's not that I am quitting. They forced me to join a group and if I don't join that group then I can no longer help you." Do you understand? And so that group is that one that makes many decisions about one. So I—that makes me uncomfortable because I say that none of those people who are sitting on the phone behind a desk knows my medical condition, anyway.*

*... I have [CMC health plan] and then I have um, uh, the one for the doctor itself cause she's—she's a part of some...I dunno. I don't understand it. Because I have to go through*

*[medical group name] then [CMC health plan] and they have to agree to do, you know, whatever [medical group name] ordered. Or one of them will say no. That's—that's been my problem because I have so many people I have to go through. I don't understand if it's the same insurance company or, you know, whatever. But it's like, real confusing.*

## Continuity of Care Provision in Cal MediConnect

Cal MediConnect includes continuity of care provisions which allow CMC beneficiaries to request to see their out-of-network provider for up to 6 or 12 months after the transition to CMC. To get this request approved, the provider must agree to CMC rates. The continuity of care provision was not well understood by beneficiaries. Most beneficiaries had not heard that a continuity of care request was an option.

**Moderator:** *Has anyone heard of the term “continuity of care request”? This [is a request you can make to the plan if] you would like to stay with your original doctor. You fill it out, so you can stay with the doctor for six months.*

**Beneficiary 5:** *I don't think so.*

**Beneficiary 4:** *Never heard of anything like that.*

**Beneficiary 1:** *Don't know what it is.*

*Well, look, I have—I had my doctor for nearly 25 years-- the primary care one. And, uh, and—I felt very sad because I had my doctor for many years. So I asked them if they could please include my doctor and they said, “we can't do it.”*

*I've heard of [COCP], but um, yeah I don't know that much about it.*

Moreover, some beneficiaries learned about the continuity of care provision stated that it was not helpful because they wanted to keep their doctors for more than six months. Thus, it would make more sense just to opt out or disenroll from Cal MediConnect.

*Yeah but I need to continue more than six months. I need five years of continual treatment. They only giving you six months.*

*Yeah, [COCP] would be great, but what if we wanna stay with our doctor for permanently? Is there anything they could do to make that happen if we don't wanna change where we are?*

Of the few beneficiaries who were aware of the continuity of care provision, there was confusion over how to go about the request or where to find more information. Beneficiaries who requested continuity of care had either a background in healthcare or assistance from an ombudsman.

*Yeah that information [about COCP] was in the material that they sent out. I wasn't able to get it on my own but I—I contacted the Ombudsman and the Ombudsman was able to arrange it for me.*

## Dental Care

Most dental care for Medicaid eligible beneficiaries in California is covered by Denti-Cal, a program separate from Cal MediConnect. But some Cal MediConnect plans do offer

supplemental dental benefits. The subject of dental care elicited mostly negative comments in the focus groups. Beneficiaries were not happy about the scope of coverage and couldn't understand why some types of dental care were not covered at all. One of the beneficiaries had dental problems which ended up precipitating a visit to the Emergency Department. Most beneficiaries reported that they had to pay out of pocket for dental care. Many complained that only basic dental benefits are covered and were disturbed by the fact that the dentists would extract teeth before they would repair them.

*I had to pay out of pocket recently for extractions and root canal and—because they won't cover it. And it is diabetes-related. —oh they cover root canals if they're in the front teeth, which is strange, and, uh, apparently certain fillings, um, I think, um, it's very limited. They were not covering what I needed, uh, which was causing additional infection, and, um, high blood sugars and, you know, overall health problems. Yeah. So, it'd be really nice if they would just cover dental. Period. If you have a dental problem, cover it. Why are they picking and choosing, you know, you can't pick and choose what's happening in your body.*

*[re: Dental coverage] It does not exist anymore. I had two teeth extracted. I paid out of pocket. \$360... \$350.*

*We just had an appointment in July. We went to the dentist at the beginning of the year. There used to be two general checkups every year, including examination, cleaning, implant. But our dentist asked us to pay \$75 at this last appointment.*

*I cannot find the information about the dental services and haven't used the benefits. No information seems available, I would like to read about it and it doesn't seem available.*

## Vision Care

Cal MediConnect offers some enhanced vision benefits. Generally, there was a great deal of confusion among focus groups participants about what vision care was covered under Cal MediConnect. The discussion revealed great variability in beneficiaries experiences with vision coverage. While some have not had to pay for eye exams or glasses, others have had to pay more out of pocket. Some have not been able to find an optometrist.

*Same with glasses. We used to have a doctor who examined our vision so we could get glasses. Now if we would like to get our vision checked we need to pay \$85. And he told us to go to another doctor.*

*I need glasses for reading and to see. I just got glasses for reading, they told me I had to wait another two years. And my glasses—my reading glasses—but my glasses I'm supposed to wear every day is broke. I called and said "My glasses are broke. What do I do now?" "Oh you have to wait another two years."*

*I done got three pairs of glasses and mine is readin' and seeing and I did got three pairs within a year.*

*[CMC called] to ask me some questions about my health. And there came up that of my vision and I told him/her, "Well, I haven't been able to get the optometrist because the*

*one I had didn't accept my insurance." And s/he said, "We are going to send a list so you—you can choose the one you want." And I haven't gotten it.*

*I paid 300 bucks. Yeah out of pocket. Cause they didn't [cover glasses].*

*Yeah I had to put out \$180 [for glasses].*

*I got mine [glasses] free.*



## BEHAVIORAL HEALTH CARE IN CAL MEDICCONNECT

In addition to the five beneficiaries who were selected to participate in in-depth telephone interviews because they used behavioral health care, many beneficiaries in the focus groups (37%) also mentioned that they used behavioral health services.

**Behavioral health access improved for many:** Of those beneficiaries who said they use behavioral health services, comments were mostly very positive about their experiences since joining CMC. Though a few reported having trouble finding psychiatrists, by far the majority reported a great improvement in their access to behavioral health care since enrolling in CMC. There were many people who commented that, under CMC, there were more mental health providers available and more services covered, and some reported that they now paid less out of pocket.

*To me, the CMC is the best because of my mental health benefits. That is what I use the most and that is what I was most excited about... The mental health services were seamless, the benefits improved greatly and the providers seemed to understand [CMC health plan] well. I previously had to pay out of pocket.*

*I would say the services are better now. They have helped me get over things I couldn't get over before. I haven't had issues with getting an authorization to see a psychiatrist.*

*I'm gonna give you a positive thing. With [CMC health plan], with my son needing psychiatric treatment, there is more providers for mental—whether it's psychiatric or psychologist—with [CMC health plan] than there was with Medicare and Medi-Cal. [Original]Medi-Cal did not hardly have any psychologists or psychiatrists... So that is a real plus.*

**Addiction services improved:** One beneficiary expressed interest in knowing what other types of behavioral health services were offered under CMC, especially addiction services. Another beneficiary said that his CMC plan paid for him to enroll in an outpatient drug rehab program, which was previously not covered.

*Addiction type services have always been hard to get, because addiction isn't seen as an illness. It would be interesting to see what services are available with CMC. Information about regular services are given out more often, but addiction services are still kind of hush hush. It is important to me to know what is available.*

**Behavioral health continuity:** Changes in new psychiatrists caused health disruption for some, but most beneficiaries who changed mental health providers were happy with the change.

*I had problems with, um, finding a psychiatrist 'cause my former psychiatrist got a promotion... So I had to find a new psychiatrist and, um, I called Cal MediConnect and they—the only one that was there for me was Dr. T. And I had bad experience with him because I take high doses of medication for my illness and they—and he recommended me that I should, um, stop taking it and take [a medication for bipolar depression], but my former psychiatrist wrote letters to my doctors to specify that they shouldn't change*

*my medication or lower it. But Dr. T was so eminent on my changing because he thought it causes osteoporosis.*

*Had to switch psychiatrists from one to another. It might not have had anything to do with the CMC. They gave me a choice to switch psychiatrists and other services due to the distance when I moved to a new apartment. Talked to both doctors and then... the transfer happened pretty smoothly once I made that decision.*

*The main thing is that the services exist now. Previously I could only use interns in school. I am so pleased that I have a psychiatrist now.*

## LONG-TERM SERVICES AND SUPPORTS IN CAL MEDICCONNECT

A major change to health insurance for dually eligible beneficiaries in demonstration counties is that long-term services and supports (LTSS) is now paid for by the Cal MediConnect health plan (or by the Medi-Cal Managed Care health plan in the case of those who opted out). LTSS includes services such as In-Home Supportive Services (IHSS) which provides payment for consumer-directed home care, as well as a variety of other services designed to help consumers live in the community, including adult day health care (CBAS), transportation, and meal delivery. Additionally, some CMC health plans are working to provide additional services called Care Plan Options, which would include things like building ramps, buying appliances, or an array of other services that are not universal benefits, but that help consumers live in the community and avoid higher levels of care. To capture beneficiaries' perceptions of these changes, two focus groups were conducted specifically with those using IHSS, and other LTSS services were brought up in all focus groups. A total of 55 focus group participants used IHSS.

### LTSS Awareness and Availability

The LTSS that were most commonly discussed were IHSS. Some mentioned CBAS and almost no beneficiaries mentioned the Multi-Purpose Senior Services Program (MSSP). Most beneficiaries were familiar with the term "IHSS." LTSS as an acronym was unfamiliar to both English-speaking and non-English speaking focus groups and had to be explained by focus group moderators. When asked about their awareness of several types of LTSS services and given examples with some names of specific programs, some beneficiaries didn't know about the services and were interested in learning more. One beneficiary said she was aware of what's available with her plan but she had some fear and anxiety with the eligibility and application process.

*Um, I don't—I don't know [Laughs]. It's, uh...I mean, I really should look into it. And—and—and see if I could have somebody come by once a week just to help me out with vacuuming and things like that. But...I'm so exhausted with going through the rigamarole. It's just—everything's, you know, I don't wanna get my hopes up for something that's gonna take so long and then who—who is coming into my house? And I'm not sure...I don't know.*

*Yeah, I'm aware [of LTSS]. Because my best friend has the—so I was aware of it. I—I don't need it.*

### In-Home Supportive Services

The most common LTSS that was mentioned by beneficiaries in the focus groups was IHSS. Because of our targeted recruitment of IHSS users, almost half (45.8%) of beneficiaries in the focus group used this service. Though the Cal MediConnect program pays for IHSS services for beneficiaries, and can coordinate with IHSS and advocate for these services for beneficiaries, responsibility for determining eligibility for this program remains the responsibility of the county Social Services department.

**Changes in IHSS hours:** In the focus groups with beneficiaries using IHSS, we asked whether the CMC had helped them to increase or decrease their IHSS hours. Most IHSS beneficiaries reported little impact or change to IHSS after joining CMC.

*Not through the health plan—well I don't know who pays for it. My daughter's my caregiver. She lives here with me and nothing's changed.*

Others reported fluctuations in their IHSS hours after enrolling in CMC. Some beneficiaries tied changes in their IHSS hours to their enrollment in CMC.

*They cut his hours. They cut his hours.*

*Mine's just cutting of the hours.*

*Mine—my [IHSS] hours went up.*

Two beneficiaries with IHSS understood that fluctuations in their hours had to do with policies at the state level and had nothing to do with CMC.<sup>†††</sup>

*Well it fluctuates. Just based on the state. So they'll take it and give it back, take it and give it back.*

*They actually it's, uh, something that just recently passed. Governor Brown finally passed and give us back the in-home care people—they gave us back our seven percent that they took away from us before which was a tremendous impact on those who truly needed more than like, I—you know, I mean it was amazing how that affect the care of people who couldn't even help themselves at all. So it was like, wheel-bound. But we just got that back. But, uh, it—No, it had nothing to do with Cal MediConnect.*

One focus group member reported having an increase in hours, but the increase was not due to advocacy on the part of the CMC care coordinator.

*I told [CMC care coordinator] I already have it. I was just getting 15 hours and now I'm getting 24 but, uh, it wasn't through [CMC health plan] or—or [CMC health plan product name]. I just walked in there and did my own—well, I called. I called and they came out. You know, they come out and um. But if we can get services through your company that may be a little better...*

*With the [CMC health plan]. when they asked me, do I have it—in-home supportive care—and I tell 'em I do, they get shocked. They're like, "What?" Because ...I've had mine for three years. So I don't have a problem with that.*

**Confusion on relationship between health plan and IHSS:** A key change in the duals demonstration is the LTSS like IHSS are now paid for and coordinated by the plan (though the county still has authority over determining eligibility). Some confusion occurred in discussions on IHSS because many beneficiaries viewed it as a separate program from their CMC health

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<sup>†††</sup> In July 2015, 7% of IHSS hours that had previously been cut were restored. All County Letter:

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-57.pdf>

plan. They did not view it as a Medi-Cal program nor did they understand the CMC plan paid for the service.

*[CMC] It has nothing to do with it. They're separate. You have to apply for In-Home Support Services separately. It has nothing to do with Medi-Cal.*

*Well, In-Home Supportive Services? That's through the county as well.*

*I know it's through the county...but it doesn't—it doesn't have anything to do with your Medi-Cal, I don't think.*

## Transportation

All beneficiaries who attended the focus groups were asked about their knowledge of and use of the new Cal MediConnect transportation benefit. About a third of beneficiaries (34%) reported using transportation services provided by their CMC plan. Only about half of beneficiaries were aware of this benefit.

*No, I wasn't aware of [CMC transportation], but I think, um, most of it is my fault because I didn't inquire much, you know. So.*

*Well I didn't know [about CMC transportation] until my daughter—my daughter told me, "Dad," I says uh, I says, you know she's the one that call for me and they called me, so they picked me up and they take me to my doctor and—and they bring me back.*

*No I didn't know. [If I knew] Yes it would be of help.*

Some beneficiaries who knew about this benefit did not utilize it because they did not need assistance with transportation.

*Right well the thing about it though as far as getting to the doctor, uh, I—I chose the doctor I did because of location. It's conveniently located to me so it's no problem getting there on a bus. Uh, but I could utilize it for something else, you know.*

*[CMC health plan] insurance provided transportation. But since my daughter can give me a ride, I do not use it.*

The beneficiaries who did use transportation services appreciated this benefit and were generally satisfied with it.

*It had been hard for me to call to get the cars because they often transfer me to many phone line. My foot really hurt at the time and had to use a cane. .... I used to have to bus to San Francisco to see my specialist and I fell once on my travel. But now that they have a transportation service, it's a lot better.*

*I think the best thing of this program is the transportation services, whenever you need. There are fifteen trips. It was more then before the switch. This is a better result.*

*My experience with [CMC health plan] transportation has been very good. They are generally on time.*

*I'm a happy camper. I said—I didn't even know about transportation and I—I was really hassling to give gas money, take me here and there and my daughter told me, I says, "[CMC health plan] has transportation. They'll pick you up and drop you off at the house."*

One beneficiary who currently does not need assistance with transportation felt that it was useful to have the benefit available should the need arise in the future.

*I liked the idea of the other services, I haven't used them yet, but I like the transportation service and I know I'll be using that in the future. I hope it is true, what they say is available. When the time comes that I can't drive anymore, I want to be able to access the transportation assistance.*

A few who used the transportation services had suggestions for how it could be improved. In one county two beneficiaries complained about being picked up late.

*They were an hour late and when I called them, they finally said they are on the way. I had nowhere to sit outside but still have to wait.*

*Yeah, they are usually not on time. They are usually 30 minutes to 1 hour late. I often worried about not being to make it on time.*

Some beneficiaries in another county said they provide a later appointment time than what it actually is because the driver picks them up earlier than necessary.

*Oh mine was good. They—they come a hour early, so I told 'em my doctor appointment is like an hour late so they be 30 minutes—cause I'm only 15 minutes away from my doctor. Or from my specialist so and I have them come—push the time up. But I have no problem, transportation is good. It's real good.*

A few people mentioned that the system is not very flexible, as you need to request a ride far in advance of your appointment.

*In, uh, [CMC Plan] has transportation benefits too, but it's hard to get them. Like, they want you to schedule 5 days before, but then all of a sudden your doctor would cancel it and, um, move it up and they cannot bring you. They would deny you, so...*

A few people felt that 30 one-way trips per year would not be sufficient for beneficiaries who have frequent medical appointments.

*Thirty rides a year. You know, miss [other participant] right here? Probably could use that up in about two months.*

*Yeah. We have appointments every week. Her chemo's almost every two weeks. She has a doctor's appointments practically every week.*

*But I don't have transportation no more. They said I used up all of mine so I don't have it no more... There's a limit on it and I didn't know it. Cause if I knew it I wouldn't have made it my doctor's appointments like I did. I could've stretched 'em out.*

Some beneficiaries thought there might be a possibility of obtaining more than 30 trips per year if requested by one's provider.

*...go have your doctor call [CMC health plan] tell them you need it they will give it to you for that date. You can't do it, though, but they have to.*

*They [doctors] also can have your rides increased.*

One beneficiary thought her disability was a barrier to using the transportation services provided by the health plan.

*They don't accommodate my disability, so...*

Some beneficiaries expressed a need for transportation for non-medical trips, e.g. errands.

*We still need the services. If they can pick us up for shopping... They do not provide us that now.*

*And I want to have more rides and that they take me to buy food. The [CMC plan] taxi isn't for grocery shopping, just for the doctor. They check the GPS to make sure I am going only to the doctor.*

*They don't allow me to go anywhere besides the doctor, so I use the bus. But I want them to also take me to the market. I can't walk a lot because I can't breathe well and I get tired quickly.*

### **Community-Based Adult Services**

Several beneficiaries and their caregivers who came to the group as proxies talked about their CMC care coordinator connecting them to a CBAS program.

*Uh, well, what it—what it is, uh, I think—actually, I think my, uh, case manager, um, I think she's the one that told me about the [CBAS] program. And, so then, I called them up and talked to them and they talked to me and we—we been communicating so we can get this going, so I'm gonna go on, uh, the 29th.*

### **Care Plan Options**

The term “Care Plan Options” (CPOs) refers to services or goods that the CMC plan can purchase for beneficiaries that are outside the general scope of other benefits. These could be things like additional home care hours, home safety modification, home cleaning, respite care, or purchasing appliances. The intention is typically to provide a one-time or short-term service that will fill a gap or prevent the need for a higher level of care. Not all CMC plans provide CPOs. There was no mention of Care Plan Options by beneficiaries in the focus groups. When it was explained to beneficiaries that the health plan might be able to purchase goods or services for them, several beneficiaries expressed interest in these services and wondered if their CMC plan provided home modifications and transportation for non-medical purposes.

*I would like to have something in the bathroom to be able to get up and bend over because I can't get up. If I had the handles they sometimes have in the bathroom then I*

*would be able to do that on my own. I would also like a taller toilet because it's too low and I have too much trouble getting up. I suppose I would call [CMC health plan] about this, but I never thought of this until now that I am talking to you about it.*



## OPTING OUT AND DISENROLLING

Though beneficiaries were passively enrolled into Cal MediConnect, they were also notified that they had the option not to enroll in the program. It was specifically stated in notification letters that they could “keep Medicare the same.” To opt out or disenroll, beneficiaries could call either Health Care Options (the Medi-Cal enrollment contractor) or they could talk to their plan. When beneficiaries decided not to enroll in CMC, they were still mandatorily enrolled in managed care plans for Medi-Cal and LTSS, but could keep their original Medicare providers. A higher percentage of beneficiaries opted out than anticipated. About 45% opted out and another 10% disenrolled. Opting out was highest in Los Angeles and Orange counties, and lowest in San Mateo county (a county-organized health system where beneficiaries were in special needs plans before the transition to Cal MediConnect). Certain language groups (Mandarin, Cantonese, Korean, Russian) opted out at higher than average rates in some counties, though Spanish speakers opted out at lower than average rates. Additionally, beneficiaries who use IHSS services (and are likely have more functional impairment) opt out at a higher rate. There is great concern about the financial viability of the program if opt-out rates are high. In order to assess reasons for and experiences with opting out, two focus groups were conducted with beneficiaries who had opted out or disenrolled from Cal MediConnect.

### Knowledge and Misconceptions about Opting Out

All focus group participants (both those enrolled in CMC and those who opted out) were asked to relay their understanding of what “opting out” meant and what impact it would have on their health insurance. When asked for the meaning of “opt out,” beneficiaries reported a wide range of interpretations.

***Misconceptions and lack of knowledge about opting out:*** Some who were enrolled in CMC did not know that they had the choice to opt out (i.e. “keep Medicare the same”). Many said that their interpretation from the information they received was that they were required to choose a CMC plan.

*Okay. My—my understanding, reading all that, was that I had to pick one.*

*... I was under the impression that the letter, I thought, stated that you—if you don't wanna change anything don't do anything. If we don't hear from you, everything stays the same.... But that was not the case. —I was already [enrolled in CMC]. But then, I had an incident where I was tryin' to get something to cover and they was like, "You're not longer—we don't have you anymore. You're with [CMC plan].*

*No I didn't know [about opting out].*

Some beneficiaries who were enrolled in CMC had misconceptions about what would happen if they decided not to enroll. Some thought that opting out would mean giving up their health insurance altogether.

*If—if you don't pick one then—you got no, um, medical insurance.*

*I read it in the letter that I could opt out, but to me that just meant that I would end up getting...just, end up having more trouble anyway. Um, not getting insurance whatsoever. Yeah.*

*So it was like a threat. [Laughs] Not getting insurance.*

Other beneficiaries who heard about opting out thought it meant that you could pick a different Cal MediConnect plan.

*Opting out means that at anytime I can pick a different plan. I don't know if there is another MediConnect plan to enroll in? I wouldn't want to opt out.*

*"Opt-out" is when I would notify [CMC health plan] that I would like to leave and no longer wish to be with them any longer. I would find a new insurance provider before informing [CMC health plan].*

Some knew they could opt out, but felt they didn't understand enough about it to know whether opting out would be best for them.

*Yes I knew [about opting out], but I don't know where to opt to? Which one is better, you know? I'd have to find something different....they told me—nothing. That's what they told me.*

In one instance, a beneficiary who had opted out did not know that they opted out of CMC.

*I have Medi-Cal-Medicare. And I was happy and, um, that way. **Moderator:** Okay. But then you've opted out of Cal MediConnect. Did somebody help you to do that? **Beneficiary:** I don't know. **Moderator:** You don't know. So right now, as you sit here, you're not sure whether you're in Cal MediConnect, whether you're not in it— **Beneficiary:** I don't really know.*

**Knowledge of opting out:** Some enrolled beneficiaries (and almost all who had opted out) did understand that they had the choice to opt out and understood what opting out meant:

*[Opt out means that I] choose not to participate.*

*Yeah just the option to get out of whatever plan that they were telling you to get into.*

*That means you can get out of the program. That's what it means to me.*

*They gave me the choice—they gave me a choice. If I wanted to or not. ... they give—they had the option on the paperwork it says it... You either join or you don't.*

A few beneficiaries did understand that if they opted out of Cal MediConnect, there were some benefits that they would not get and some providers they would not be able to see.

*On that conference call [Cal MediConnect Telephone Town Hall] ...There was a lot of discussion about the benefits. .... They were like all for like, this is the greatest thing on earth and if you choose [CMC health plan] or [another CMC health plan] you're losing whatever where it wasn't the case.*

*[I was told], your benefits are decreased once you don't join.... Oh yeah. You have a lot of copayments.*

**Moderator:** *Yeah? You knew that you could opt-out? That's one, two—all of you. Yeah? And what would happen if you opted out?* **Beneficiary:** *Well, no dental and vision, for starters.*

Some who understood that they could opt out did not use the term “opt out”.

*—well the “opting out,” we don’t use that term because we didn’t know. So—so when we say we want to remain the same. We wanna remain the same.*

### **Reasons for Opting Out or Disenrolling from Cal MediConnect**

Focus group participants who opted out of the Cal MediConnect program were asked to relay all of their reasons for opting out. Many who opted out believed that CMC would take away their freedom of choice, reduce consumer direction, and increase government control of their lives.

*... you'd have to go to whoever the assigned primary doctor is with the health plan and get special paperwork to process and it's a big hassle, and what for? ... You become a number.*

*...It's not that we don't wanna change, it's more or less we are so used to, uh, having the freedom to go a doctor of our choosing—of our chosen—whether we're out of state or out of the city, we can still go to, uh, a doctor where we feel comfortable going to. Being enrolled into a Medi-Cal Connect plan, we're, uh, restricted. And you're going to a doctor of our choosing, for one, and two, you have to call Medi-Cal Connect to see if each accepts—who accepts the plan you're under, according to their, uh, rules and regulations. It's another form of government control.*

*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. Or I can have, uh, a choice of a specialist that I felt maybe could, uh, you know they have more experience or more qualified versus someone who's in their group who, maybe, I have no choice. I have to go to that person.*

**Opting out to keep the same providers:** The most common reason why beneficiaries said they had not enrolled was because they wanted to stay with a PCP or specialists who were not part of a CMC plan. Many times they described longstanding, close relationships with a current provider that they were not willing to give up. Many believed they would “fall through the cracks” if they were forced to find a new doctor.

*That's what's so important about being able to choose your doctor is like, if—I don't know what I would do if we couldn't see the specialists my parents were seeing and our primary doctor. You know, we've been going to our primary doctor—we actually drive out of the way to where we used to live and it's like a 30-minute drive once a month for my parents. And it's—you know, he knows them. He knows their medical situation. He knows all of their specialists. He talks to them, they all communicate with each other.*

*And—we feel comfortable there. Like, if we hopped around from doctor to doctor, you know, they could fall through the cracks and not get the care they need.*

*Well, the way it started out, was that, uh, because you know even before all this stuff was coming down the pipe, my doctor that I've been going to for the past like fif—over 15 years told me that if uh, if I ended up in a CMC program that he could no longer see me. So, so [opting out] was like a no brainer.*

*[If you stayed in CMC] You'd lose the ability to see doctors that you've been going to for the last 20 years... It'd have been a nightmare.*

**Not restricted to network providers:** Beyond just wanting to keep their current providers, beneficiaries stated more broadly that they wanted to have the freedom to see any doctor they wanted to in the future and did not want to be restricted to health plan network providers. This was especially of interest to individuals who thought they might need to go to doctors out of state or out of the country.

*Ah but you know, by keeping our Medicare we can go to any doctor we want to at any time.*

*I'd also like to say that one of the reasons about this because you have much more choices with [original] Medi-Cal. You can go anyplace...more.*

**No need for prior authorization to go see a specialist:** Some beneficiaries also said they opted out because they did not want to have to obtain prior authorization to see a specialist.

*It would have created a—a big hassle for us because before when we had Medicare/Medi-Cal, we were considered "Medi-Medi." We didn't have to have prior authorization to go see a specialist, we didn't have to have—we didn't have to wait, um, for prior authorization, we didn't have to go to our primary care. Um, most of the time the primary care would refer us over there, but we didn't have to wait for somebody else to make a decision whether we were qualified enough or we had the—the um, the right condition enough to be seen by a specialist. Um, and by enrolling in Medicare Connect—er, MediConnect, it took my rights away from choosing the doctor that I wanted to go to.*

**Happy with current care:** Several beneficiaries indicated that they were satisfied with their current care and so there was little incentive to make a change. Some liked that their providers were geographically close by and didn't want to make a change. One also noted that their doctors already have their medical records and they didn't want to start with a new doctor where they would have to relay all of that information again.

*That's what I think. It's been working all these years, for all these people, now all of a sudden you wanna throw this in here and everybody's supposed to just jump.*

*If it ain't broke, don't fix it!*

*... I like having the way it was. Medi-Cal and Medicare the way it was before. That was my first choice...*

*[After opting out] Well I still see the same doctor....He can refer me—if I—when I go to it's—look. When I need to get a colonoscopy, he refers me to the doctor. All that's the same everywhere I'm at. And it's right—it's, you know, my doctor is ... just right around the corner. My hospital is... Right around the corner. Everything's right there. And it's all in—in the system.*

*They already see what medications I take. I didn't have to—I came in carrying a bag of, uh, prescriptions or a list of medications I was taking. I just do this.*

**Rumored changes to IHSS hours in CMC:** There was one beneficiary who mentioned that beneficiaries who use IHSS services were under the impression that they would lose some IHSS hours if they joined CMC. This was a misconception, and it was not clear how widespread this rumor is, but it may be a clue as to why the opt-out rate among IHSS users was higher.

*Is because the Medi—yes. Because they were losing things that—I'm talking about people who truly can't function on their own. And they were losing, uh, certain, uh, well the hours. They were gonna lose—there was hours that they possibly would lose. They would have to get a new in—a second in-home care person because they were not gonna, you know, authorize the overtime. And so if, you know, you needed say, uh, forty hours and you were only gonna get twenty, what are you gonna do with the rest of that time? So you would have to get a second person so that you could go into overtime, which means the uncomfot of having to train a new person and, uh, using a lot of that was family members that were taking care of that person to begin with. And so you were gonna have to bring in either another family member and/or a stranger to do that for you. And I could really go on and on about that because I'm very passionate about that, because thank you, God, I can still function on my own. But when you stop and think about the fact that you have to take a bath and to eat, you gonna need somebody to do that for you. So, yes, we have the highest—and when I say we I'm speakin' of the service people. Yeah, they dropped out. And also, who's gonna take care of my wheelchair? Who's gonna give me my—my—what do you call it—incontinence? Yeah. Who's gonna give you your supplies? They weren't furnishing the supplies. They lost the supplies to be able to go—yah? Think about that. Go have a bath and, uh—*

**Lack of information instigated opting out:** Another contributing factor in the decision to opt out, for some beneficiaries, was the feeling that they did not have sufficient time or information to make an informed decision. For people with complex care needs, seeking information about whether each of their multiple providers, medications, and DME are covered was seen as a great deal of work. One beneficiary said she would have needed more time to go through every medication, and since she didn't have that, she opted out. Beneficiaries mentioned both a lack of information in the letter and poor information when they called HCO or the CMC plan prompted them to opt out.

*Uh, well you get confused because this insurance cover this, this insurance cover this, this cover this, and—I dunno what to do...No I just keep my Medi-Cal-Medicare, that's it.*

*There was no information [in the original letter].*

*Not only that, when you called them you don't get it—they were very confused. They were very confused.*

**Changes in coverage for supplies and prescription medications:** A few beneficiaries had been enrolled in CMC, but they decided to disenroll when they discovered that their CMC health plan would not cover certain services or that their copay had increased.

*And I asked—asked to be taken out of it because the first thing I got in the mail was a letter saying that they wouldn't cover my insulin. So I have—I'm diabetic. I have to have insulin. You know. So that was my main reason.*

*[I opted out because] I received bills because I have a stoma and I get supplies every month and I receive a bill from them and say that I owe like half—they only pay half of my bill. And I call and ask them why, you know, they sent me a bill and they say it's "Oh because your insurance doesn't cover." I say, "Well, how come if they always been covered?" And then also my prescriptions I have—I have to pay from \$1.70 or a dollar something to three dollars and something cents.*

Another major theme that emerged among those who opted out was fundamental mistrust of Cal MediConnect and, more broadly, the government. Others understood that the Cal MediConnect program is a temporary “untested” new program and they were unsure it would remain in place.

*Well you know, they've provided or they've, you know, put out all these incentives with all this extra stuff. Eye vision and all this other stuff we've talked about to get you to, you know, enroll in this Cal MediConnect, but, you know, who knows what the real outcome is gonna be, you know? In five years, you know, down the road. Who—because it's untested. Nobody knows is it gonna happen, is it gonna work? And you know, we're all used to doing what we're doing that's been working for so long, why should we jump into this thing that the government is enticing us with all this extra stuff. I don't trust the government.*

**Some CMC enrollees changed their minds about opting out:** A few beneficiaries who enrolled in CMC said they had considered opting out, but are now happy they did not.

*[I did consider opting out] at one time. They—the first time that I told you I tried to keep my Medicare and, uh, my Medi-Cal straight but then I was forced to get to a group thing. It's when I start, uh, making calls and I get the [CMC health plan] information. Now if you ask me today if I want to opt out from, eh, my insurance company, I say no.*

*I didn't have any experience and I thought my Medicare, you know, and Medi-Cal straight—I [would] have a better choice to go to different doctors. But then, eh, eh—*

*In the beginning I didn't want it, and after I started using it, I loved it. Tell people not to be so skeptical. I wanted everything to stay the same.*

**Some who opted out saw care coordination as reduced autonomy:** In the focus groups with beneficiaries who were not enrolled, beneficiaries were informed about some of the additional benefits that CMC plans provide, such as transportation, care coordination and additional dental in some plans. They were then asked whether these benefits were appealing and, if so, whether

knowledge of these benefits would change their mind about enrolling in the program. Some beneficiaries who opted out conceded that care coordination might be helpful, but many said they were not ill enough to need that service. Some others thought (or worried) that having a care coordinator would take away their autonomy or choices. Beneficiaries expressed concerns about their freedom to make decisions and choices with a care manager. They preferred advice rather than someone telling them what to do and wanted to remain in control of their decision-making.

*Yeah, cause I don't wanna be told I have to go to this doctor, you know....*

*Sure. So like, somebody who will work with you, not necessarily tell you "You need to see this doctor and do this," but to say something like that, "Look, you're in chemo and, you know, these services are available to you if you want us to help you get them." That would be helpful.*

*Yeah because even somebody—like, you're very proactive in your own health care, but you don't know all the options that are available to you.... I would like the advice, but I want to be able to make decisions.*

*As long as I'm able mentally to [coordinate my own care], I would prefer to do it. Because I know my body better than anybody else. I know [my mother] inside out, upside down, and nobody from the outside knows us better than we do. So as long as I'm in my right mind and can still make my own choices, I prefer to do that.*

*Leave Medicare, ... with Medicare. That Cal MediConnect doesn't make sense. You know I just see that layer like this coordinator person add a layer so somebody don't know me and will make decisions for me, and fifty other people that's she's making for decisions for and—they could be too busy, on drugs or something. So it can make mistakes ... I don't need that—that extra, uh, whatever added to my life now.*

*But this service [care coordination] still doesn't take away from you making your own decisions, right? I mean this service is not that—you still can make your own decisions but somebody helping you to coordinate things. It doesn't mean you have to do it their way, right?... No I'm just wondering I don't know.*

## **Process of Opting Out**

Most of the beneficiaries who opted out of CMC did not find the process difficult and did not require help. They opted out either by completing the choice form or calling Health Care Options.

*[Disenrolling] It was easy... I just did it on the phone.*

*To me, I was so upset and I call and when I found out about these bills and then they—I was, I don't have [original MMC health plan] anymore so I call and complain, "Why? I didn't sign any paper or anything. Why wasn't that, uh, insurance?" And so I was complaining and I just told 'em. I don't wanna—I wanna get out of this and go back to [original MMC health plan]," and that's it.*

*Well it seems to me if I can remember, which I can't all the time, [opting out] was just checking a box and sending it back in.*

A few proxies reported assisting the beneficiary they were representing at the focus group. One person sought assistance from an independent living center.

*And then I went to the Center for Independent Living people who were, you know, instrumental in guiding me through the whole process...*

One beneficiary did report that she had to be on the phone for a long time to disenroll from a CMC plan.

*And then I disenrolled because I got a letter, and I didn't even know. I said—well, then I called. But to clear that out, I was on the phone forever.*

### **Experiences With Care After Opting Out or Disenrolling**

Beneficiaries who opted out were allowed to keep their original Medicare, but they still had to enroll in a Medi-Cal managed care plan for their Medi-Cal (which pays 20% of provider visits) and LTSS. Despite this, most who opted out of CMC generally felt that their medical care was largely unchanged. They noted that they were able to continue seeing the same providers as before. The most commonly reported change was the need to get pre-authorization from their Medi-Cal Managed Care plan to see specialists. A number of beneficiaries said some specialists just accept the 80% that Medicare pays so they do not need to get pre-authorization from the MMC plan.

*Well I go to a podiatrist every, every six weeks. My daughter and I both. And um, podiatry is considered a specialty. And under our program that we have now we should be having a referral. But we never have to have one, and I think it's because he only takes the Medicare. He doesn't bill [MMC health plan] and he just lets the 15 or 20% go. Because we've seen him for so many years and— He lets the other percentage go.*

***Some disruptions after opting out:*** A few also reported delays in seeing their PCP. One beneficiary attributed this wait to the higher volume of patients that had joined the clinic since the demonstration began. A few people reported that they now have copays for office visits where before they did not.

*For [another beneficiary], it would be appointments right away. When—when—when they started this a year and a half, two years ago, we could get an appointment within a day or two. ...Now it's up to a month. Unless you're sick. If you're sick, you know, they try to work you in.*

*I'd say, um, when I call my—my doctor for an appointment I wouldn't be able to see him for about two months. I could come in and see the PA... But when I have—when I'm told two months, you know, I know it's because of the volume of all the new patients that he's received, um, uh, I don't know, you know, I really don't know if they were really prepared for how much it was gonna encompass as far as getting all this new—all these new patients they're gonna be receiving. Staff-wise and even their old office. They weren't really prepared ...*



There were a few reports of needing to change prescription medications since opting out, mostly due to changes in their Part D plan's formulary. Some said they were able to appeal and get their original medications covered. Most reported little or no change in copays for prescriptions, but some reported increases. Most beneficiaries who opted out had no copay for medical equipment and supplies. A few reported delays (e.g., in getting a pacemaker/defibrillator and hearing aids).

## LANGUAGE SERVICES

Focus groups were conducted with beneficiaries in Spanish (19), Cantonese (12) and Mandarin (7). Approximately 32% of focus groups participants spoke a non-English language as their primary language.

### Notification Letters and Information From the Plan in Non-English Languages

Most beneficiaries whose first language was not English reported receiving the letter notifying them of their enrollment into Cal MediConnect and other materials from their health plan in their primary language.

*I received the [Cal MediConnect] forms in Spanish and English.*

*And it told me that I had to fill out--to find or to fill out that form and choose... I got it in Spanish.*

*At first, the forms are in English and we ended up writing in Chinese at the end of the form which says that we can't understand English and they eventually sent us forms in Chinese.*

*Yeah, because when they send one a letter, --I read it. All the way at the end it says, "if you need the letters to be sent in Spanish, call this phone number." ... that's how I did it. And they do send them in Spanish.*

A few, however, reported not receiving written materials from the health plan in their language.

*After my husband passed away, I don't understand the notices that I received because it is in English.*

*And I already told them in the--in the plan--the [CMC health plan], I told them to please send me things in Spanish because there's just a little bit that I understand.*

When calling CMC member services, Spanish, Cantonese, and Mandarin speakers reported they were usually able to talk to someone in their primary language. Many were very pleased with their ability to communicate with the CMC plan in their own language.

*I want to give thanks to [CMC health plan] for their Chinese service. If I don't understand, then I call. They are very responsive with calls. I call them if I have any questions.*

*I did. I did call. I was in my house. It was silent and no one was there and I grabbed all the papers I had and I called [the CMC health plan]. And they did help me really well. And they said to me, "you are in Health Net. There is no problem. We are going to send you--" **Moderator:** And did they help you in Spanish? **Beneficiary:** Yes, they helped me in Spanish and everything. Yes. And s/he said to me, "you don't have any problem. You're fine. You have [CMC health plan]. You have your same doctor and your same clinic."*

*Yeah, they help me in Spanish. It says right there, when one calls it says, "dial number 1 if it's in English, dial number 2 if it's in Spanish." And one just dials. It says, "wait just a*

*moment, right now they're going to--they're going to help you." And in a moment, they help me. They talk to me in Spanish.*

### **Communicating with Providers in non-English Languages**

A few beneficiaries related anecdotes demonstrating how essential receiving medical information in their own language is.

*In my case, I asked for the female doctor because, uh, she is Hispanic and speaks Spanish. I defend myself [when speaking English], but sometimes—my comfort was with the American doctor—it was—sometimes when I would go home, I would say to myself, “Did he understand my problems?” Do you understand? That's because I explain to him, but in reality, I have talked to friends of mine who dominate the language perfectly and sometimes I think that it's one word and they say, “That's not this, that's that.” Do you understand how it is? ...and to avoid that problem, the last time I went I said, “No, look. I want to see [Hispanic doctor].”*

*In one occasion, I had to take my mom to a specialist and the nurses—the people who were at reception told me that if I didn't speak Spanish—English, they couldn't help me. Because I had to fill out some forms [to get an interpreter]. And then, truthfully, I felt like the ground should just swallow me .... Then, s/he told me, “make another appointment,” I told her/him, “How can I make another appointment?” I told her/him. I didn't bring an interpreter or anything. ...There were people who spoke English—Spanish, sorry. I know that there were some. And they didn't want to help me. They said, “You have to fill out this paperwork.” ... So what I did. I felt ashamed. I even felt like crying. So what I said—I said, “No, I am not leaving.” I told her, “I'm not leaving. You have to help me.” And what I did was I asked those who were arriving, because there wasn't even a lot of people there at the clinic, that if they knew English and Spanish so they could help me fill out a form. And a person did help me. And that person didn't speak Spanish well, but could understand it. So between the two of us, we could fill out the forms and they did help me.*

*Also, my right eye couldn't see all of a sudden. [The doctor] gave me a pill and called me the next day but neither my daughter nor me could understand because we just immigrated here at the time.*

*I asked if there are any other ways [to treat his condition] and he said physical therapy, and I asked him not to assign an English-speaking physical therapist. And I've seen other English-speaking physical therapists and two months would pass with no results. I was starting to lose confidence. The girl at the physical therapy place spoke Cantonese so I was able to understand, and she printed examples of the poses I should be doing for me. My health improved ever since and I'm able to do those exercises at home. She was very good. I used to have to use a cane.*

Some beneficiaries with limited English proficiency reported seeing providers who speak their language. One beneficiary noted a lack of local providers in the plan network who speak his language.

*[I would recommend that the CMC plan] add more specialists who speak Chinese (Cantonese and Mandarin). There are very few in [our county]. We need to go to*

*Chinatown [in non-CCI county] to see specialists since we cannot speak English very well.*

A few beneficiaries said they choose to see providers who do not speak their language (despite the difficulty communicating) because they like the provider.

*I go to the African-American doctor because I think he is very caring... He looks at all the little things... And he checks everything so I do not want to switch doctor. I know [another primary care doctor] speaks Cantonese and I've seen him twice. I don't want him as my family physician. I go to the African American doctor because he is very detail oriented and I have my daughter to go with me as interpreter.*

*[Explaining why she has not changed to a Spanish-speaking provider] My doctor only speaks English and [providers' office] gives me someone who interprets. But the thing is that I have gained confidence in that doctor, because through her I've--I've gone to the specialists, right? So I have the trust that I've placed on her. It wouldn't be easy to give it to another person. That's why I'm always there with her.*

One of the biggest difficulties faced by beneficiaries with limited English proficiency was that written communication sent by providers was often in English only. Appointment reminders and medication labels were two such areas that posed barriers for non-English-speaking beneficiaries.

*Yes, the letters are in English. I have a problem understanding them. The letters my doctor sends me about my appointments or exams are in English, too, and I don't understand them.*

*There was this once when a patient asked him [primary care doctor] what the English medication label means, and he said "I'm not an interpreter."*

### **Access to Interpreter Services**

When beneficiaries see a provider who does not speak their language, many were able to access interpreting services through their provider's office, particularly those who got care in larger clinics or hospitals.

*Government hospitals provide good interpretation services. There are machines that interpret in Cantonese and Mandarin.*

*I go to [clinic name] to see doctor for my diabetes. There are a lot of English medical terminologies but they were very good with interpreting. Other interpreters at other hospitals are not as good.*

*On Monday I went to a cardiologist and I had a scheduled appointment, but—I asked them if they spoke Spanish. I said, "Well, then I won't be able to go to the appointment," I told him/her, "because I don't understand English." And then s/he says, "Well, and if we change the time of—of, um—of—of the appointment? I said, "Well, if they are going to speak Spanish that's fine and if not, well, then cancel it." And s/he just changed the time—the schedule. That was it. And they helped me in Spanish.*

However others said that it is difficult to access interpreting services through their doctor's office, and especially specialists' offices. They often relied on other office staff or were asked to bring family members to interpret for them. Some expressed a desire for greater access to interpretation services. Few seemed to be aware that these services were available through Cal MediConnect.

*Yeah, some doctors, especially specialists do not have interpreters or even nurses. The patients need to bring interpreters.*

*I hope that interpretation services will help to improve communication.*

*Most hospitals already have interpretation services but clinics do not have it yet.*

*Sometimes they demand that a relative comes along in order for them to help me. So, my daughter goes with me, the two of us enter, and the doctor addresses both of us and he tells my daughter many things that I am not hearing. But s/he demands that my daughter come along.*

*I also hope that doctors... for example, my kidney doctor is Indian and the person who brings me to see the doctor often lacks the medical knowledge. I hope there is some kind of interpretation.*

*His office does not provide such [interpreting] services. ... It would be even better if translation services were in place.*

*Don't think any office provides any translation services.*

*Generally, we do not have any problem communicating with our doctor. Just some medical terms [that he said] in English which we do not understand. Under those circumstances, we write things out [in Chinese characters (the doctor speaks Cantonese and the beneficiaries speak Mandarin)].*

*...sometimes there isn't [an interpreter] ... So I try to communicate with the doctor, but I can't. ... A little. A little [problem].*

Only one beneficiary mentioned receiving interpretation service through her CMC health plan. She noted that while the requirement to request an interpreter five days in advance made it difficult to access interpretation if she needed care urgently, the health plan usually tried to help her in those cases, and she appreciated the service.

*But I—with me, they have always tried to search for me, even if there are 2 days—2 days left until the appointment. They have told me that it has to be at least 5 days. I say, "I know. I am conscious of that, but they are giving me the appointment now." They do what they can and they always send me the interpreter and, truthfully, I do feel good.*

## 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. The research revealed a range of experiences, with many common themes. Additionally they explored why some beneficiaries decided against enrolling in the plan. As is typical in qualitative studies, participants were not randomly sampled and instead selected to represent the diversity among the population. Thus, results are not necessarily generalizable to the entire Cal MediConnect population. On the other hand, 14 focus groups with 120 beneficiaries are sufficient to document common "themes" that arise repeatedly among beneficiaries when discussing their experiences, as reported here. Focus groups are also quite useful for documenting the subtleties and complexities behind attitudes toward the program, and the types of language beneficiaries use to describe the program. These focus group results were useful for developing and refining a quantitative telephone survey that is being fielded in CMC counties with beneficiaries. Results of that quantitative survey will be available in the spring of 2016.

To link to a summary of focus group key findings with recommendations, go to [http://www.thescanfoundation.org/sites/default/files/cal\\_medicconnect\\_key\\_findings\\_brief\\_march\\_2016.pdf](http://www.thescanfoundation.org/sites/default/files/cal_medicconnect_key_findings_brief_march_2016.pdf).

## APPENDICES

### Appendix A: Focus Group Screening Form

#### Coordinated Care Initiative Evaluation Focus Group Screening Form

##### INITIAL RETURN CALL

Hello, this is [INT NAME] from UC Berkeley returning a call from [RNAME]. Is [RNAME] available?

- R AVAILABLE-> GO TO INTRO SCRIPT
- R NOT AVAILABLE-> **When would be a good time to call back, or is there another number that would be better to reach [RNAME]?**

DAY(S): \_\_\_\_\_

TIMES(S): \_\_\_\_\_

ALT PHONE: \_\_\_\_\_

**OK, great. I'll try calling back then. Thank you for your time.**

##### INTRO SCRIPT—CONSENT TO BE SCREENED

[Hi, this is [INT NAME] from UC Berkeley]. I'm returning your call about the Cal MediConnect Study at UC Berkeley. Thanks for getting in touch with us. This research study is about people's experiences with Cal MediConnect health plans. If you are eligible and you agree to take part, then you would attend a two-hour focus group, where you will have a discussion with 8-10 other people. We will audio record the focus group. You will also be asked to complete a brief questionnaire. After the focus group, you will receive a \$50 Target gift card. May I ask you a few questions to see if you are eligible? You can skip any questions you don't want to answer. [NOTE: If a participant is interested, but unable to travel to a focus group due to disabilities, you can offer the alternative of doing an individual phone interview instead, subject to supervisor review.]

- YES-> **OK, great.** [CONTINUE TO GENERAL SCREENING QUESTIONS]
- NO-> **OK. Did you have any questions about the study?** [ANSWER QUESTIONS AS NEEDED, THEN ASK]:

**Would you like to see if you are eligible?**

- YES-> **OK, great.** [CONTINUE TO GENERAL SCREENING QUESTIONS]
- NO-> **OK. Thanks for your time.** [RECORD AS REFUSED]

**GENERAL SCREENING QUESTIONS**

NOTE: If at any point during the screening the potential participant says that he/she is a health care proxy for a dually eligible beneficiary, rather than being a dual him/herself, skip to the PROXY SELF-CERTIFICATION and then ask the screening questions about the participant using the wording in brackets.

**S1. First, what county do you [does RNAME] live in?**

- LOS ANGELES
- SAN BERNARDINO
- SAN DIEGO
- RIVERSIDE
- SANTA CLARA
- SAN MATEO
- Other [Specify]: \_\_\_\_\_

**S2. How old are you [is RNAME]? [SPECIFY AGE]: \_\_\_\_\_**

[IF R CANNOT SPECIFY PRECISE AGE, ASK RANGES]

- 65 OR OLDER
- 18 TO 64
- 17 OR YOUNGER [GO TO INELIGIBLE SCRIPT UNLESS SPEAKING TO PROXY]

**IF SPEAKING TO PROXY, ALSO ASK:**

**S3. How old are you? [SPECIFY AGE]: \_\_\_\_\_**

[IF R CANNOT SPECIFY PRECISE AGE, ASK RANGES]

- 65 OR OLDER
- 18 TO 64
- 17 OR YOUNGER [GO TO INELIGIBLE SCRIPT]

**[ONLY ASK IN SAN BERNARDINO, RIVERSIDE, LOS ANGELES AND SAN DIEGO COUNTIES]**

**S4. Did you receive a flyer in the mail?**

- YES→ASK: **What color was the flyer?** [DO NOT ASK IN RIVERSIDE—INSTEAD ASK TIME OF FG FROM FLYER]
  - BLUE AND GREEN [CARE COORDINATION]
  - BLUE AND ORANGE [IHSS]
  - OTHER (SPECIFY) \_\_\_\_\_
  - DON'T KNOW
- NO
- DON'T KNOW

**S5. Are you [Is RNAME] enrolled in Medicare?**

- YES



- NO-> [ASK]: **S5A. What health coverage do you [does RNAME] currently have?**

---

- HAS HEALTH COVERAGE, ASK: **S5A1. Is that paid for by Medicare or by somebody else?**
  - PAID FOR BY MEDICARE [MAY ALSO BE PAID FOR BY MEDI-CAL]
  - PAID FOR BY SOMEBODY ELSE-> [GO TO INELIGIBLE SCRIPT]
  - DON'T KNOW-> SEE NOTE ABOVE. ASK THEM TO LOOK AT THEIR HEALTH CARDS. A MEDICARE CARD HAS RED, WHITE, AND BLUE STRIPES ACROSS THE TOP. IF STILL DOESN'T KNOW, GO TO PROXY IDENTIFICATION SCRIPT. IF SPEAKING TO PROXY, GO TO INELIGIBLE SCRIPT.
  - NO HEALTH COVERAGE-> [GO TO INELIGIBLE SCRIPT]
- DON'T KNOW-> [NOTE: ASK THEM TO LOOK AT THEIR HEALTH CARDS. A MEDICARE CARD HAS RED, WHITE, AND BLUE STRIPES ACROSS THE TOP.] IF STILL DOESN'T KNOW, GO TO PROXY IDENTIFICATION SCRIPT. IF SPEAKING TO PROXY, GO TO INELIGIBLE SCRIPT.

**S6. Are you [Is RNAME] also currently enrolled in Medi-Cal?**

- YES
- NO-> [ASK]: **S6A.What health coverage do you [does RNAME] currently have?**

---

- HAS HEALTH COVERAGE, ASK: **S6A1.Is that paid for by Medi-Cal or by somebody else?**
  - PAID FOR BY MEDI-CAL [MAY ALSO BE PAID FOR BY MEDICARE]
  - PAID FOR BY SOMEBODY ELSE-> [GO TO INELIGIBLE SCRIPT]
  - DON'T KNOW-> SEE NOTE ABOVE. ASK THEM TO LOOK AT THEIR HEALTH CARDS
  - NO HEALTH COVERAGE-> [GO TO INELIGIBLE SCRIPT]
- DON'T KNOW-> [ASK IF THEM TO DESCRIBE THE KIND OF CARD THEY SHOW AT APPOINTMENTS.]
  - IF HAS MEDI-CAL CARD OR PLAN MEMBERSHIP CARD->CONTINUE
  - IF DOES NOT HAVE CARD->[GO TO INELIGIBLE SCRIPT]
  - IF STILL DOESN'T KNOW, GO TO PROXY IDENTIFICATION SCRIPT. IF SPEAKING TO PROXY, GO TO INELIGIBLE SCRIPT.

**[ONLY ASK FOR SANTA CLARA COUNTY]**

**S7. What is your [RNAME's] birth month?**

- BIRTH MONTH HAS **NOT** PASSED SINCE SANTA CLARA COUNTY TRANSITIONED (January 1, 2015) -> [GO TO INELIGIBLE SCRIPT]
- BIRTH MONTH HAS PASSED SINCE SANTA CLARA COUNTY TRANSITIONED

**[ASK ONLY IF THEY HAVE NOT ALREADY TOLD YOU THEIR CMC PLAN]**

**S8. Did you [Did RNAME] enroll in a Cal MediConnect health plan sometime in 2014 or 2015?**

[IF NEEDED, EXPLAIN: Starting in [MONTH/YEAR] most people in [NAME] County who have both Medi-Cal and Medicare (aka Medi-Medis or duals) were required to join a managed care plan. [DOES NOT APPLY IN ALL COUNTIES: Usually people had to make this change in their birth month.] Most people were automatically enrolled in a plan called a Cal MediConnect plan. Once enrolled, you get both your Medicare and Medi-Cal benefits through this one health plan. The plans available in [NAME] County are [NAMES OF COMPANY AND SPECIFIC CMC PLAN]. People with both both Medi-Cal and Medicare could decide to not join or “opt out” of the Cal MediConnect plan and continue receiving Medicare the way they always have (aka “straight Medicare”). However they would still have to be part of a managed care plan for their Medi-Cal benefits. [IF PARTICIPANTS SEEM UNCLEAR ABOUT THE DIFFERENCE, EXPLAIN THAT IN “REGULAR” MEDICARE YOU CAN GO TO ANY DOCTOR WHO TAKES MEDICARE, BUT IN A CAL MEDICONNECT HEALTH PLAN, YOU HAVE TO SEE DOCTORS WHO BELONG TO THE PLAN’S NETWORK.]

- YES
- NO→ [ASK:] **S8A. Did you [RNAME] have a chance to enroll in a Cal MediConnect health plan but then decided to keep your [his/her] Medicare benefits the same (sometimes called “opting out”)?**
  - YES [ELIGIBLE FOR ‘OPT OUT’ FOCUS GROUP; SKIP TO QUESTION S11]
  - NO→ [NOTE: ASK THEM TO LOOK AT THEIR HEALTH CARDS TO SEE IF THERE IS ONE WITH A CMC PLAN NAME ON IT.] IF STILL DOESN’T KNOW, GO TO PROXY IDENTIFICATION SCRIPT. IF SPEAKING TO PROXY, GO TO INELIGIBLE SCRIPT.
  - DON’T KNOW→ [NOTE: ASK THEM TO LOOK AT THEIR HEALTH CARDS TO SEE IF THERE IS ONE WITH A CMC PLAN NAME ON IT.] IF STILL DOESN’T KNOW, GO TO PROXY IDENTIFICATION SCRIPT. IF SPEAKING TO PROXY, GO TO INELIGIBLE SCRIPT.

**S9. [IF NOT ALREADY ANSWERED] What is the name of the Cal MediConnect health plan you are [RNAME is] currently enrolled in?**

[PROMPT:] **The name should be on your [RNAME’s] plan membership card.**

[SPECIFY PLAN]: \_\_\_\_\_

[PLANS BY COUNTY]

<u>County</u>	<u>Cal MediConnect Plans</u>
Los Angeles	L.A. Care
	CareMore
	Care1st Health Plan
	Health Net

	Molina Health Care ( <i>Molina Dual Options Cal MediConnect Plan</i> )
Santa Clara	Anthem Blue Cross
	Santa Clara Family Health Plan
San Bernardino	Inland Empire Health Plan ( <i>IEHP DualChoice Cal MediConnect Plan</i> )
	Molina Health Care ( <i>Molina Dual Options Cal MediConnect Plan</i> )
San Diego	Care1st Health Plan
	Community Health Group ( <i>CommuniCare Advantage</i> )
	Health Net
	Molina Health Care ( <i>Molina Dual Options Cal MediConnect Plan</i> )
Riverside	Inland Empire Health Plan ( <i>IEHP DualChoice Cal MediConnect Plan</i> )
	Molina Health Care ( <i>Molina Dual Options Cal MediConnect Plan</i> )
Santa Clara	Anthem Blue Cross
	Santa Clara Family Health Plan
San Mateo	Health Plan of San Mateo ( <i>CareAdvantage Cal MediConnect Plan</i> )

- ON LIST OF CAL MEDICONNECT PLANS FOR COUNTY
- NOT ON LIST OF CAL MEDICONNECT PLANS FOR COUNTY [FINISH SCREENING, THEN GO TO SUPERVISOR REVIEW]
- NOT CURRENTLY ENROLLED IN A CAL MEDICONNECT PLAN → [ASK:] **S9A. Did you [Did RNAME] enroll in a Cal MediConnect health plan but then decide to get out of the plan and go back to the way your [his/her] Medicare benefits were before?**
  - YES [ELIGIBLE FOR ‘OPT OUT’ FOCUS GROUP; SKIP TO ‘IF ELIGIBLE’ SECTION BELOW]
  - NO → [GO TO INELIGIBLE SCRIPT]
  - DON’T KNOW
  - REFUSED

**S10. [IF THEY OPTED OUT, SAY: Even if you opted out of Cal MediConnect, you were required to join a managed health plan for your Medi-Cal.] Since you [RNAME] enrolled in that plan, have you used or tried to use the plan? For instance, have you seen or tried to see a doctor, gotten a prescription filled, or gotten medical supplies?**

- YES [NOTE TYPE OF SERVICE IF MENTIONED  
\_\_\_\_\_]
- NO → [GO TO INELIGIBLE SCRIPT]

**S11. Before you enrolled in your health plan did you receive your Medi-Cal benefits through a Medi-Cal health plan?**

- YES→[GO TO INELIGIBLE SCRIPT]
- NO
- DON'T KNOW

**S12. Do you [Does RNAME] have a disability?**

- YES→ASK QUESTION S12A BELOW
- NO→SKIP TO QUESTION S13

**S12A. IF YES, ASK->What type of disability do you have? (DO NOT READ LIST, BUT CHECK ALL THAT APPLY BELOW)**

- INTELLECTUAL DISABILITY (I.E. LEARNING DISABILITY ETC.)
- DEVELOPMENTAL DISABILITY (I.E. AUTISM, CEREBRAL PALSY, SPINA BIFIDA, ETC.)
- MENTAL HEALTH DISABILITY (I.E. BIPOLAR, SCHIZOPHRENIA, DEPRESSION, ETC.)
- BRAIN INJURY (I.E. STROKE OR TRAUMATIC BRAIN INJURY)
- PHYSICAL DISABILITY (I.E. SPINAL CORD INJURY, MS, ARTHRITIS, ETC.)
- BLIND OR VISION IMPAIRMENT
- DEAF OR HARD OF HEARING
- SUBSTANCE ABUSE
- CHRONIC ILLNESS
- OTHER (SPECIFY)\_\_\_\_\_

**IF OPTED OUT, SKIP TO ELIGIBLE SCRIPT.**

**[ONLY ASK IN COUNTIES WHERE WE ARE HOLDING AN IHSS FOCUS GROUP (SAN BERNARDINO AND RIVERSIDE)]**

**S13. Have you [Has RNAME] used In-Home Supportive Services (IHSS) since you [he/she] enrolled in your [his/her] Cal MediConnect health plan? [IF NEEDED EXPLAIN: IHSS is a program that pays for someone to come to the home of seniors and people with disabilities and help with things like personal care, laundry, meal preparation.]**

- YES
- NO
- DON'T KNOW

**[ONLY ASK IN COUNTIES WHERE WE ARE HOLDING A CARE COORDINATION FOCUS GROUP (SAN BERNARDINO AND RIVERSIDE)]**

**S14. Each Cal MediConnect health plan has people who can help health plan members coordinate their health care. These people are sometimes called care managers, nurse, or care coordinator. Care managers and coordinators helps members with things like creating a care plan for you, referrals to specialists or arranging transportation. As far as you know, have you [has RNAME] talked to someone from the care coordination department like a**

care manager, nurse or care coordinator since you [he/she] enrolled in your [his/her] Cal MediConnect health plan? [NOTE: FOR IEHP MEMBERS HAVE CARE MANAGERS (OFTEN JUST CALLED NURSES) AND CARE COORDINATORS ON THEIR TEAM.]

- YES
- NO
- DON'T KNOW

**[ONLY ASK IF CALLING IN RESPONSE TO FLYER FOR PHONE INTERVIEWS WITH BENEFICIARIES WHO HAVE EXPERIENCED HOMELESSNESS]**

**S15. Have you experienced homelessness in the past year?**

- YES
- NO
- DON'T KNOW

**[ONLY ASK IF CALLING IN RESPONSE TO FLYER FOR PHONE INTERVIEWS WITH BENEFICIARIES WHO USE BEHAVIORAL HEALTH SERVICES]**

**S16. Have you used any mental health services in the past year? [IF NEEDED, YOU CAN USE THIS DESCRIPTION OF MENTAL HEALTH CARE: This is care you get for things like depression, anxiety, or conditions like schizophrenia. It can be provided by a primary care doctor, a psychiatrist, or other professionals like psychologist or counselor.]**

- YES
- NO
- DON'T KNOW

**[ONLY IF THE FOCUS GROUP THEY QUALIFY FOR IS NOT IN THE LANGUAGE YOU ARE SPEAKING WITH THEM, SAY:]**

**S17. It looks like you would qualify for a focus group in your county, but it is in [LANGUAGE]. Would you feel comfortable participating in a [LANGUAGE] focus group? [IF THEY QUALIFY FOR AN ENGLISH FOCUS GROUP AND A FOCUS GROUP IN ANOTHER LANGUAGE, YOU CAN OFFER THEM A CHOICE OF LANGUAGES.]**

- YES
- NO
- DON'T KNOW (EXPLAIN) \_\_\_\_\_

IF THEY MEET THE REQUIREMENTS OF ONE OF THE SPECIFIC FOCUS GROUPS IN THEIR COUNTY, GO TO ELIGIBLE SCRIPT. IF NOT, GO TO INELIGIBLE SCRIPT.

**INELIGIBLE SCRIPT: I'm sorry, but it looks like you are not eligible to participate. Thank you so much for your interest. We really appreciate it. RECORD AS INELIGIBLE**

**SUPERVISOR REVIEW SCRIPT: Thank you for answering those questions. I'll need to get back to you to let you know if you are eligible. [GO TO Q-E2]**

**ELIGIBLE SCRIPT: From the answers you gave it looks like you are eligible to participate in this research study. Are you interested in participating?**

- YES→ **OK, great.**
- NO→ **OK. Do you have any questions about the study?**
  - NO→ **OK. Thanks for your time today.** → RECORD AS REFUSED
  - YES→ [ANSWER QUESTIONS AS APPROPRIATE AND CONTINUE]

Now that we've talked about that, do you think you would like to participate?

- NO→ **OK. Thanks for your time today.** → RECORD AS REFUSED
- YES→ **OK, great.**

**E1. Do you need any accommodations to make it easier for you to take part in the focus group? [Prompt: For example, some people might need to communicate using an interpreter or need to have the materials in large print.]**

- NO ACCOMMODATIONS NEEDED
- YES, ACCOMMODATIONS NEEDED  
[SPECIFY]: \_\_\_\_\_

\_\_\_\_\_

**E2. May I get your full name and contact information so that we can get back to you with further information?**

PARTICIPANT NAME \_\_\_\_\_

EMAIL \_\_\_\_\_

PHONE NUMBER(S) \_\_\_\_\_ BEST TIME TO CALL \_\_\_\_\_

**We would like to remind you about the focus group the week before. Would you prefer an email, phone call or text message reminder?**

SPECIFY: \_\_\_\_\_

[IF NEEDS SUPERVISOR REVIEW, THANK RESPONDENT AND SAY WE WILL GET BACK TO THEM]

[IF SPEAKING TO ELIGIBLE BENEFICIARY CONTINUE TO FOCUS GROUP DETAILS]

**FOCUS GROUP DETAILS**

**Great. Let's see which focus group we can schedule you for. SCHEDULE POTENTIAL PARTICIPANT FOR MOST APPROPRIATE FOCUS GROUP BASED ON THE**

LANGUAGE SPOKEN AND INFORMATION PROVIDED (E.G. SENIORS, YOUNGER PEOPLE WITH DISABILITIES, IHSS USERS, CARE COORDINATION USERS, PEOPLE WHO OPTED OUT).

**Here are the details for your focus group:**

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

LOCATION: \_\_\_\_\_ [PROVIDE DIRECTIONS OR ARRANGE TO EMAIL THEM]

**PROXY IDENTIFICATION SCRIPT**

**PI1. You can also have someone [help answer these questions/come to the discussion group] with you or for you. Is there someone like a family member or friend who helps you make health care decisions [like choosing doctors or filling out medical paperwork]?**

- NO, NO ONE ASSISTS -> CONTINUE SCREENER IF UNFINISHED, THEN GO TO SUPERVISOR REVIEW
- YES, SOMEONE ASSISTS-> [ASK]: **What is this person's first name?** [SPECIFY NAME]: \_\_\_\_\_ [RECORD ON PARTICIPANT CONTACT LOG]

**P1A. Would you like to have [PROXY NAME] [help answer these questions and possibly] come to the discussion group with you or for you?**

- YES
- NO-> **P1A1. Is there someone else you would like to have come to the discussion group with you or for you?**
  - YES-> GET PERSON'S NAME: \_\_\_\_\_ [RECORD ON PARTICIPANT CONTACT LOG]
  - NO-> CONTINUE SCREENER IF UNFINISHED, THEN GO TO SUPERVISOR REVIEW

**PI2. May I please speak with [PROXY NAME]?**

- YES-> GO TO PROXY INTRO SCRIPT
- NO-> PROXY IS UNAVAILABLE OR LIVES ELSEWHERE
  - PI2A. When would be a good time to call [PROXY]?**

DAY(S): \_\_\_\_\_

TIME(S): \_\_\_\_\_

[RECORD ON PARTICIPANT CONTACT LOG]

- PI2B. What is the best phone number to reach [PROXY]?**

[ENTER PROXY'S PHONE # \_\_\_\_\_]

**Great. I'll try calling [him/her] at that time. Thank you for your help.**

[WHEN PROXY IS REACHED, GO TO PROXY INTRO SCRIPT]

#### PROXY INTRO SCRIPT

Hello, my name is [INT NAME] and I'm calling from the University of California, Berkeley. [RNAME] contacted us about taking part in a study about people's experiences with Cal MediConnect health plans. [RNAME] said that you help [him/her] make decisions about [his/her] health care and that [he/she] would like you to [help answer the eligibility questions and] participate in the research [with [him/her]/on [his/her] behalf]. If you and [RNAME] are eligible and you agree to take part, then you would attend a two-hour discussion group [with or for RNAME]. After the discussion group, [RNAME] will receive a \$50 gift card to Target. Is it OK for me to ask you a few questions to see if you and [RNAME] are eligible? [GO TO GENERAL SCREENING QUESTIONS]

#### PROXY SELF-CERTIFICATION

**P1. Are you willing to serve as a research respondent on behalf of [RNAME]?**

- YES-> **OK. Great.**
- NO→ **OK.** [RECORD AS PROXY REFUSED AND GO TO Q P3A]
- DON'T KNOW-> **P1A. Do you have any questions I could answer for you?**  
[ANSWER AS APPROPRIATE, THEN RE-ASK P3]

**P1B. Do you know of someone else who helps [RNAME] with [his/her] health care decisions, like choosing a doctor or filling out medical paperwork?**

- YES-> RETURN TO PROXY INTRO SCRIPT
- NO, DON'T KNOW OF ANYONE ELSE-> [GO TO SUPERVISOR REVIEW SCRIPT]

**P2. And what is your relationship to [RNAME]? Are you [RNAME's] friend, family member, conservator, guardian, or something else? [IF SAYS "FAMILY MEMBER" ASK]: And how are you related?**

- R's FRIEND
- R's CONSERVATOR OR GUARDIAN
- R's SPOUSE OR DOMESTIC PARTNER
- R's ADULT SON OR DAUGHTER
- R'S PARENT
- R'S ADULT BROTHER OR SISTER
- R'S ADULT GRANDCHILD
- ADULT WITH SOME OTHER RELATIONSHIP TO R→ **P2A. Please describe your relationship to [RNAME]:**



[SPECIFY:] \_\_\_\_\_

**P3. Do you help [RNAME] with [his/her] health care decisions, like choosing a doctor or filling out medical paperwork?**

- YES-> GO TO QUESTION S1
- NO

**P4. [IF NO]: Even though you do not help [RNAME] with [his/her] health care decisions, are you familiar with [RNAME's] health care needs and experiences?**

- YES->GO TO QUESTION S1
- NO-> PROXY INELIGIBLE-> GO TO QUESTION P5
- DON'T KNOW-> PROXY INELIGIBLE->GO TO QUESTION P5

**P5. I'm sorry. We need someone who [is familiar with [RNAME's] health care needs and experience/is able to represent [RNAME's] wishes in this research]. Do you know of someone who helps [RNAME] with [his/her] health care decisions, like choosing a doctor or filling out medical paperwork?**

- YES-> RETURN TO PROXY INTRO SCRIPT
- NO, DON'T KNOW OF ANYONE-> GO TO INELIGIBLE SCRIPT

## Appendix B: Focus Group Consent Form

UNIVERSITY OF CALIFORNIA AT BERKELEY

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO



SAN FRANCISCO • SANTA BARBARA • SANTA CRUZ

### CONSENT TO PARTICIPATE IN RESEARCH

**TITLE OF STUDY:** Evaluation of California's  
Dual Alignment  
Demonstration: The  
Coordinated Care Initiative

**INVESTIGATOR:** Carrie Graham, PhD  
School of Public Health  
University of California,  
Berkeley

#### Introduction

Our team at the School of Public Health at the University of California, Berkeley is inviting you to be part of a research study. We are inviting you to participate in this study because you receive both Medicare and Medi-Cal benefits and recently enrolled in a Cal MediConnect health plan or decided to “opt out” of joining a Cal MediConnect health plan and keep your Medicare as it was before. Or you may be someone who helps someone like this with making health care decisions.

#### Purpose

The purpose of this research study is to learn more about beneficiaries' experiences with recent changes to Medi-Cal and Medicare in California.

#### Procedures

If you agree to be in this study, you will be asked to come to a focus group with 8 to 12 other Medicare/Medi-Cal beneficiaries. Before the group discussion, we will ask you to complete a questionnaire with some questions about your health, age, gender, ethnicity, education, and household composition. This will take about 10 minutes. We will ask everyone what it has been like to choose, sign up for and use your Cal Medi-Connect health plan. (If you decided not to join a Cal Medi-Connect health plan, we will ask you about making this decision.) One of the researchers will lead the discussion. It will be in a language you understand. If you allow us, we will make sound recordings of the discussion. The discussion will take about 1-1½ hours.

**Study time**

Participation in this study will take a total of two hours of your time.

**Study location**

The discussion will be located at a community center or other place that is easy to get to.

**Benefits**

You do not get any direct benefit from being in this research. But your answers will help us understand more about what it was like to decide about joining a Cal MediConnect health plan or not, and how beneficiaries' care is under these plans. We hope to use what we learn to help make the process of switching to a Cal MediConnect health plan better for other people in the future.

**Risks/Discomforts**

As with all research, if you participate, there is some risk to your confidential information. The next section tells about what the researchers do to protect your confidential information. We also ask everyone participating in the group not to share the discussion outside the group. But there is a risk that participants might share confidential information with people outside the group.

Also, if you participate, you may risk feeling uncomfortable when discussing personal health-related topics. You are free to skip any questions you do not want to answer and to leave the focus group at any time. If you decide not to answer a question or if you leave the focus group early you will still receive your \$50 gift card.

**Confidentiality**

Your study data will be handled as confidentially as possible. If results of this study are published or presented, individual names and other personally identifiable information will not be used. The researchers cannot guarantee that other focus group participants will keep confidentiality.

To minimize the risks to confidentiality, we will do the following:

Personal identifiers will be removed from your questionnaire data. We will only identify your data with an ID number, not your name. The key connecting your name and ID number will be saved on a password-protected server and encrypted.

After the group discussion, the audio recording files will be saved on a password-protected server and encrypted. We will type up the audio recording to make a written record of the discussion. Then we will destroy the audio recording.

Electronic records of your data including screening data, questionnaire data, and focus group notes will be stored on a password-protected server in our office. Hard copies of screening forms and

questionnaires will be kept in a locked filing cabinet in our offices until they are data-entered/typed. After data entry the hard copies of the forms will be destroyed.

Only the researchers will have access to your study records.

### **Future use of study data**

The research data will be maintained for possible use in future research by myself or others. I will retain for seven years after the study is over. The same measures described above will be taken to protect confidentiality of this study data.

### **Compensation/Payment**

You will receive a \$50 gift card for your participation in this study.

### **Costs**

You will not be charged for any of the study activities.

### **Rights**

Participation in research is completely voluntary. It is up to you to decide if you want to participate or not. If you decide to participate, you can skip any questions you do not want to answer. And you can leave the discussion group at any time. You have the right to decline to participate or to withdraw at any point during the study without penalty or loss of benefits to which you are otherwise entitled. Your Medi-Cal and Medicare benefits will not be affected.

### **Questions**

If you have any questions now, please ask us. If you have questions about the discussion group or the research later, you can contact the lead investigator, Carrie Graham, at 510-982-6026 or by email at [howsyourcare@gmail.com](mailto:howsyourcare@gmail.com) or [clgraham@berkeley.edu](mailto:clgraham@berkeley.edu).

If you have any questions or concerns about your rights and treatment as a research subject, you may contact the office of UC Berkeley's Committee for the Protection of Human Subjects, at 510-642-7461 or [subjects@berkeley.edu](mailto:subjects@berkeley.edu).

### **Consent**

You will receive a copy of this consent form to keep.

If you wish to participate in this study, please sign and date below.

---

Participant's Name *(please print)*

Date

---

Participant's Signature

---

Date

---

Person Obtaining Consent

---

Date

## Appendix C: Focus Group Pre-survey

### Cal MediConnect Study

#### Focus Group Pre-Survey [CMC enrollee version]

[NOTE: If you are representing someone that you help care for at the focus group instead of yourself, please answer the questions for the person you are representing. For example, we would like to know how many times the person you help care for has gone to the doctor, not how many times you have gone to the doctor.]

#### ABOUT YOUR HEALTH

1. In general, how would you rate your health?

- Excellent
- Good
- Fair
- Poor
- I don't know/prefer not to answer

2. In the **last six months**, how many times did you visit a primary care doctor to get care for yourself?

- None
- One time
- Two times
- Three times
- Four or more times
- I don't know/prefer not to answer

A primary care doctor is the one you would see if you need a general check-up, want advice about a health problem, or get sick.

3. In the **last six months**, how many times did you visit any kind of specialist to get care for yourself?

- None
- One time
- Two times
- Three times
- Four or more times
- I don't know/prefer not to answer

Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors and others who specialize in one area of health care.

4. About how many different prescription medicines are you currently taking?

- None

- 1 to 3
  - 4 to 6
  - 7 to 9
  - 10 or more
  - I don't know/prefer not to answer
5. How often do you have a hard time reading or understanding written materials about health care, like directions for taking medicine or letters from the doctor or pharmacy?
- Never
  - Sometimes
  - Usually
  - Always
  - I don't know/prefer not to answer
6. As you may know, most people in [name of county] who have both Medi-Cal and Medicare were required to change into a managed care plan in the last year or two. The plans available in [name of county] are [names of CMC health plans in county]. Which plan do you currently belong to?
- [List of CMC health plans in county]
  - Other: \_\_\_\_\_
  - I don't belong to a managed care plan.
  - I don't know/prefer not to answer
7. When were you first enrolled in this plan? \_\_\_\_\_ (month/year)
- I don't know/prefer not to answer

8. Since you enrolled in your new health plan, which of the following services have you used or tried to use? (CHECK ALL THAT APPLY)
- Primary care
  - Specialist care
  - Pharmacy services
  - Medical equipment
  - Medical supplies
  - Mental health services
  - In-Home Supportive Services (IHSS)
  - Care coordination or navigation services
  - Transportation services
  - Other: \_\_\_\_\_
  - None of the above
  - I don't know/prefer not to answer

## **ABOUT YOU**

9. What is your age? \_\_\_\_\_
- I don't know/prefer not to answer
10. Are you male or female?
- Male
  - Female
  - I don't know/prefer not to answer
11. Which one or more of the following would you use to describe yourself?
- African American or Black
  - American Indian or Alaska Native
  - Asian
  - Latino/a or Hispanic
  - Native Hawaiian or Other Pacific Islander
  - White
  - Other \_\_\_\_\_
  - I don't know/prefer not to answer



12. What is the highest grade or year of school you completed?

- Never attended school
- Elementary school (grades 1-8)
- Some high school (grades 9-11)
- High school graduate or equivalent (grade 12 or GED)
- Some college or technical school (including AA/AS degree)
- College graduate (BA/BS degree)
- Some graduate school (no advanced degree)
- Graduate degree (master's, doctorate, other professional degree)
- I don't know/prefer not to answer

13. Including yourself, how many adults live in your household? \_\_\_\_\_

- I don't know/prefer not to answer

**Thank you for participating in this discussion group!**

## Cal MediConnect Study

### Focus Group Pre-Survey [Opt-out version]

[NOTE: If you are representing someone that you help care for at the focus group instead of yourself, please answer the questions for the person you are representing. For example, we would like to know how many times the person you help care for has gone to the doctor, not how many times you have gone to the doctor.]

#### ABOUT YOUR HEALTH

1. In general, how would you rate your health?
  - Excellent
  - Good
  - Fair
  - Poor
  - I don't know/prefer not to answer
  
2. In the **last six months**, how many times did you visit a primary care doctor to get care for yourself?
  - None
  - One time
  - Two times
  - Three times
  - Four or more times
  - I don't know/prefer not to answer

A primary care doctor is the one you would see if you need a general check-up, want advice about a health problem, or get sick.
  
3. In the **last six months**, how many times did you visit any kind of specialist to get care for yourself?
  - None
  - One time
  - Two times
  - Three times
  - Four or more times
  - I don't know/prefer not to answer

Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors and others who specialize in one area of health care.
  
4. About how many different prescription medicines are you currently taking?
  - None
  - 1 to 3
  - 4 to 6

- 7 to 9
  - 10 or more
  - I don't know/prefer not to answer
5. How often do you have a hard time reading or understanding written materials about health care, like directions for taking medicine or letters from the doctor or pharmacy?
- Never
  - Sometimes
  - Usually
  - Always
  - I don't know/prefer not to answer
6. As you may know, most people in [NAME] County who have both Medi-Cal and Medicare were automatically enrolled in a managed care plan called a Cal MediConnect plan for both their Medicare and Medi-Cal in the last year or two. People could choose not to enroll in one of these new Cal MediConnect plans though and keep their Medicare the same as it was before. Did you choose not to enroll in one of these new Cal MediConnect plans? This is sometimes referred to as "opting out."
- Yes, I opted out → Skip to Question 8
  - No, I didn't opt out; I joined a Cal MediConnect plan.
  - I don't know/prefer not to answer
7. [ONLY ANSWER IF YOU JOINED A CAL MEDICONNECT PLAN] Did you enroll in a Cal MediConnect health plan but then decide to get out of the plan and go back to the way your Medicare benefits were before?
- Yes, I enrolled in a plan and then later decided to get out of the plan.
  - No, I enrolled in a plan, but I stayed in the plan.
  - I don't know/prefer not to answer

8. In the past year, which of the following services have you used or tried to use? (CHECK ALL THAT APPLY)

- Primary care
- Specialist care
- Pharmacy services
- Medical equipment
- Medical supplies
- Mental health services
- In-Home Supportive Services (IHSS)
- Care coordination or navigation services
- Transportation services
- Other: \_\_\_\_\_
- None of the above
- I don't know/prefer not to answer

## **ABOUT YOU**

9. What is your age? \_\_\_\_\_

- I don't know/prefer not to answer

10. Are you male or female?

- Male
- Female
- I don't know/prefer not to answer

11. Which one or more of the following would you use to describe yourself?

- African American or Black
- American Indian or Alaska Native
- Asian
- Latino/a or Hispanic
- Native Hawaiian or Other Pacific Islander
- White
- Other \_\_\_\_\_
- I don't know/prefer not to answer

12. What is the highest grade or year of school you completed?

- Never attended school
- Elementary school (grades 1-8)
- Some high school (grades 9-11)
- High school graduate or equivalent (grade 12 or GED)
- Some college or technical school (including AA/AS degree)
- College graduate (BA/BS degree)

- Some graduate school (no advanced degree)
- Graduate degree (master's, doctorate, other professional degree)
- I don't know/prefer not to answer

13. Including yourself, how many adults live in your household? \_\_\_\_\_

- I don't know/prefer not to answer

**Thank you for participating in this discussion group!**

## Appendix D: Focus Group Codebook

### Codebook Version 8, Revised on November 29, 2015

#### 1. **SPECIFIC SERVICE CODES:** Use these when a person is talking about this type of care. It will often be appropriate to double-code with other issues.

- **Primary care**
- **Specialty care:** Includes laboratory services and testing, physical, occupational and speech therapy, acupuncture (does not include vision services, dental services or behavioral/mental health – see additional service codes below)
- **Acute care:** Includes hospitalizations, emergency care, surgeries, inpatient services.
- **Behavioral health:** Any reference to psychiatry, counseling, psychotropic meds, substance abuse. Even if it is mentioned in passing this code should be applied.
- **Medications and pharmacy:** References to medications or pharmacy services; if talking about getting supplies from a pharmacy, code as **DME/supplies** instead of pharmacy.
- **DME & supplies:** Includes pacemakers, blood sugar test strips, wheelchairs
- **Vision services**
- **Dental services**
- **Language services**
- **Transportation services:** Will most often be applied to knowledge of transportation benefits, the use of the transportation benefits. Will often be double-coded with misconceptions, for example when participants don't know how many rides are available. Knowledge of the transportation benefit, use of the transportation benefit. Double code misconceptions (wrong number of rides) or unanswered questions or other supplemental codes where appropriate.

#### 2. **SUPPLEMENTAL CODES**

- **Satisfaction and positive changes:** This code should be applied to any comments in which participants explicitly express their satisfaction with a specific service or provider, but also to comments that capture an objectively positive change in care or coverage. Examples of this would be finally having access to specialty care or paying less out of pocket. If participants describe being pleased because nothing changed, apply this code. If they describe things being the same but don't explicitly state they are happy about it, do not apply any codes. Always double code with a **specific service code** or with **attitudes** code.
- **Disruptions, dissatisfaction and negative changes:** This code should be applied to any comments in which participants explicitly express their dissatisfaction with a specific service, i.e. "I'm not happy with my primary care doctor," or comments that refer to an objectively negative change. This code should also be applied to any comment that refers to disruption of ongoing service (i.e., not being able to see your long-time physicians, having to pay out of pocket, or not being able to fill prescriptions). For the opt-out group, apply this code if they talked about how either the opt-out process or passive enrollment kept them from getting the care they needed or having to pay out-of-pocket.

#### 3. **Knowledge/Understanding of Cal MediConnect**

This refers specifically to whether or not participants understand that CMC combines Medi-Cal and Medicare into a managed care plan (the big picture of what CMC is). This code should be applied when participants respond to moderator reading the definition of CMC. Should additionally be applied to comments that imply uncertainty about a specific component of CMC. Should be applied if they provide factual information suggesting they

have knowledge of the plan in general or a specific attribute of the plan. Also includes comments that imply participants use a preferred terminology to refer to their Cal MediConnect plan.

- **Misconceptions about a specific service:** Use when they state something that is clearly wrong about a specific service or CMC in general. Double code with specific service if applicable
- **Unanswered questions:** Applied when they say they have a specific question or they tried to get a question answered that didn't get answered. Applied any time a participant says they don't know something about their health insurance. Double code as information seeking if they actually tried to get their question answered.
- **Understands Cal MediConnect:** Participants state they have heard of CMC or correctly explain it to another participant.
- **Does not understand Cal MediConnect:** Participant states they have never heard the term "Cal MediConnect," or does not know the distinction or relationship between CMC and the health plan or the name of the health plan product they have. Double code as **misconception** if they specifically explain something that is wrong. Double code as **unanswered questions** if they ask a question. Double code with **specific service code** if they mention something specific.

#### 4. **Notification and Enrollment**

This is when they first learned about Cal MediConnect. Use this code for only when they were first notified. This code should also be applied any time participants talk about their experience with notification and enrollment - to comments about choosing to enroll in a CMC plan and reasons for doing so. Include comments about staying with PCP, specialist, suppliers, hospitals, medical groups, pharmacists, or DME supplier being a reason for choosing CMC plan; comments about adequacy of provider network; and comments about choosing a plan because the coverage is better/more comprehensive. Use supplemental codes like **satisfaction and positive changes, disruption/dissatisfaction, misconceptions** where appropriate. Double-code with **information seeking and advice** when participants describe getting advice about enrollment or finding additional sources of information to inform their choice.

- **Mailing from state or health plan around the time of enrollment**
- **Other forms of notification**

#### 5. **Information seeking & advice**

Any advice or information they got about Cal MediConnect other than the first notification. Describes any instance in which a participant seeks information from either the health plan or a third party (providers, Health Care Options, group presentations, friends, families, or community and governmental organizations and advocates). Also applies to any comments about calling member services.

- **Consulted with a provider:** Any provider - PCP, Specialist, DME supplier, pharmacist, etc.
- **Called Health Care Options**
- **Went to a group presentation**
- **Community and governmental organizations and advocates:** Any outside non-profit or community organization, HICAP, Medicare office, or independent living centers
- **Consulted with friends and family**
- **Calling Member Services/Health Plan:** This is different than a care coordinator. This is calling the number on the back of their card to get a problem solve. The plan would probably

consider it care coordination. If they specifically mention talking with their care coordinator from the health plan, code as care coordinator instead of this code.

## 6. Rating of plan selection

Comments in response to moderator asking what your rating of the plan is. These should be coded in aggregate, as the moderator has each participant one-by-one give their rating on a scale of 1-10. These excerpts would NOT be coded with attitudes towards CMC code too unless they made more specific comments (other than just a number).

## 7. Opting Out

*Anything about opting out whether they opted out or not. Code ALL excerpts from opt-out focus groups with the opt-out parent code.*

- **Reasons to opt-out:** Use this code even for those who didn't opt out saying why they would in the future. Received advice to opt-out (double code with **information seeking**). Wanted to stay with the same provider (double code with **specific service** and **changing providers**). Wanted coverage option not available through CMC. Wanted to coordinate their own care (such comments will often be double-coded with the **attitudes** code).
- **Reasons for not opting out:** Comments from those who opted in and didn't know that opting out was an option or don't understand what opting out means should be double coded with **misconceptions** under the knowledge code.
- **Actions taken and process of opting out:** Includes activities such as calling Health Care Options or visiting the IEHP offices or calling the plan to opt out.
- **Feelings about re-enrolling (for opt outers):** What plan would have to do or offer to get me to re-enroll. I would enroll if I couldn't take charge of/coordinate my own care (double code as care coordination). I would enroll if my illness got worse.
- **Non-CMC care among opt-outs:** Applied specifically to those who opted out who are describing **the care they are getting on non-CMC plans after opting out**. Also should be applied when participants who opted out describe changes in their care that they attribute to the CMC transition. Double code with any **specific service** and **satisfaction and positive changes** or **disruption/dissatisfaction** just as you would for comments about care in CMC.

## 8. Attitudes towards Cal MediConnect or managed care in general

This code should be applied to any comments about feelings toward the plan overall (if the code is clearly positive or negative always double code **satisfaction and positive changes** or **disruption/dissatisfaction**). Also apply to opt-out participants' comments about specific components of CMC and feelings about CMC. If they refer to a specific service and not CMC or their plan in general, that should be coded using one of the **specific service codes**.

- **Attitudes towards managed care:** Comments about managed care (either implicitly or explicitly). Attitudes about requiring referral by PCP and pre-authorization for services, having a 'gatekeeper.' Comments on being relieved that things are "taken care of."
- **Mistrust of the health plan**
- **Disempowerment/resignation/autonomy/choice:** Comments about feeling they don't have any power or control over the transition, passive acceptance of the transition or assignment to a PCP, etc. Comments about lacking adequate choices, e.g. choice of health plans. Comments about not wanting somebody else in charge of your health care, wanting to be able to direct their own health care.
- **Suggestions for improvement:** This code will often be applied after the moderator asks participants to provide suggestions on how the plan can be improved. These comments should be double-coded (with **specific service codes** or **communication**, for example).



## 9. Continuity of Care Requests

Anything about knowledge of or use of continuity of care requests. Preferring to opt out rather than use the COCR (double code as **opt out**).

## 10. Care Coordination services or benefit

Any comments about the care coordinator benefit or a specific care coordinator. Do not code if they refer to a care coordinator/case worker who is clearly NOT from the CMC plan. If it's unclear whether the participant is instead referring to someone from an outside agency who serves the same purpose as the care coordinator, code anyway. Examples of statements that should be coded are: "I don't have a care coordinator, but would like to have one," or "I don't know how to get one" (double code with **unanswered questions**).

- **Personal experiences with care coordination:** Only use this code for comments from people who acknowledge they have a care coordinator from the CMC plan. Double code with **satisfaction and positive changes** or **disruption/dissatisfaction** (if applicable). Double code with **specific service** if the care coordinator helped them get access to DME or specialty care for example.
- **Knowledge of care coordinator:** Apply to initial responses showing whether or not they know that the service exists; i.e. don't need to apply to every reference to a care coordinator the participant makes.

## 11. HRA Survey

Any comments about receiving surveys from the plan in the mail. It will most likely not be clear whether or not participants are discussing the HRA survey since they themselves did not seem sure why they were receiving surveys or the differences between them. Examples of statements include: "Survey comes too frequently by phone or mail," "I don't fill out the survey because it comes too often," "The survey is too useless or long," or "I filled out the survey when they gave me an incentive (i.e. gift card)."

## 12. Individualized Care Plan

"I did/didn't receive an individualized care plan." They saw their care plan and knew what is/was. They didn't know what a care plan was or never heard of it (double code as **knowledge**). Double code with **satisfaction and positive changes** or **disruption/dissatisfaction** if they say they liked or didn't like their ICP.

## 13. Long-Term Services and Supports (LTSS)

Any comments about IHSS, MSSP, CBAS, or evidence of extra services being provided by the plan that help plan members stay in the home (e.g. CMC plan offering care plan options like buying them a washing machine). This will often be double-coded with the **knowledge** code if participants are uncertain about how LTSS is associated with CMC or if they have not heard of LTSS. Should be applied to any mention of LTSS.

- **In-Home Supportive Services (IHSS):** Comments about whether IHSS changed with transitions, including changes in IHSS hours.
- **Multipurpose Senior Service Programs (MSSP)**
- **Community-Based Adult Services (CBAS)**

## 14. Communication in Cal MediConnect Plans

These codes are generally applied to comments relating to communication after the transition (although not exclusively). These will often be double-coded with "Disruptions,

dissatisfaction and negative changes” and with specific service codes. Make sure to apply to comments about how materials provided by the plan are confusing, inaccurate, too detailed, etc. Code comments about seeking information about the transition from the plan with the **information seeking** code instead of this code. Code comments about information sent by the plan at the time of transition with the “**Mailing from state or health plan around the time of enrollment**” code instead of this code. Most of these comments will relate to **miscommunications**.

- **Communication between health plan and providers:** Comments from participants that suggest that the health plan and providers aren’t communicating. Example: pharmacy charges patient for services that should be covered.
- **Communication between health plan and beneficiaries:** Includes comments about being confused by the information the plan provided to them (whether by phone, mail, etc). Example: health plan tells a member that a provider is in their network but they really are not. OR Had a good experience communicating with someone at the plan when called them. Does not include comments related to communication with care coordinator specifically
- **Communication between providers and beneficiaries:** Includes doctors telling participants they don’t know anything about CMC.
- **Communication between different providers:** Includes comments about how providers are or are not communicating with each other about a patient’s care, e.g. PCP knows what tests the specialist ordered, etc. This captures what we were calling ‘care coordination’ (not the care coordinator benefit). Double code with **Interdisciplinary Care Team** if that is what they are talking about.

#### **15. Changing plans**

Comments about experiences switching from one CMC plan to another or desire to switch from one plan to another. Do not use this code if they are commenting on changing between plans that are not CMC plans, e.g. before the CMC transition. Reasons for switching from one plan to another (double code these as a **specific service, disruptions, dissatisfaction and negative changes** or **misconception** as appropriate).

#### **16. Changing providers**

Comments about changing or keeping your specific provider; may include pharmacy or DME vendor as well as physicians. Includes comments about having to change providers when they didn’t want to, changing when they wanted to, not knowing they could change providers, process of changing, frequency allowed to change PCPs, etc. Always double with a **specific service code**. Note that not being able to find a doctor should instead be coded with **disruptions, dissatisfaction and negative changes**.

#### **17. Paying out-of-pocket**

Apply to any discussions about having to pay for services that aren’t covered under the plan and cost-sharing (copays) or any changes in the amount of money being paid out-of-pocket (i.e. paying less). Always double-code with a specific service they are paying for.

#### **18. Disability access**

Anything that had to do with having a hard time getting into and out of the doctors’ office, on the exam table, getting weighed, etc.

#### **19. Referrals & authorization for services**

Increased wait-times to get certain services (e.g. see specialists or obtain prescriptions or DME) due to needing pre-authorization. Comments about not needing pre-authorization

before transitioning to CMC. Confusion about or problems with pre-authorization. Issues accessing specific services because of the pre-authorization process. Always double code with a **specific service code**. If it caused a disruption in care, double code with disruptions, dissatisfaction and negative changes. Double code as **disruptions, dissatisfaction and negative changes** or **satisfaction** where appropriate.

**20. Medical groups**

This code refers to comments about medical groups or physician associations. These groups have contracts with the health plan and then take responsibility for that beneficiary's care so there might be comments about having to get authorization for a service both from the health plan AND the medical group. This does not come up often.