



Coordinated Care Initiative

EVALUATION OUTCOME REPORT

January 2016

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Executive Summary

Welfare and Institutions Code Section 14132.275(m) requires the Department of Health Care Services (DHCS) to conduct an evaluation, in partnership with the Centers for Medicare and Medicaid Services, to assess outcomes and the experience of Medicare-Medicaid enrollees (Duals) in the Duals Demonstration Project, known as Cal MediConnect. DHCS is required to provide a written report to the Legislature after the first full year of demonstration operation, and annually thereafter, and must consult with stakeholders regarding the scope and structure of the evaluation.

In order to accommodate for the delayed and staggered implementation of the Coordinated Care Initiative, which Cal MediConnect is one component, DHCS modified the due date for this report. DHCS informed the Legislature of the adjusted timeline in June of 2015.

Background

The Financial Alignment Initiative – Partnerships to Provide Better Care

In July 2011, the Centers for Medicare and Medicaid Services (CMS) announced the opportunity for states and CMS to better coordinate care for Medicare-Medicaid enrollees (Duals) under the Financial Alignment Initiative through two different demonstration models:

1. **Managed fee-for-service** in which a state and CMS enter into an agreement by which the state would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.
2. **Capitated model** in which a state and CMS contract with health plans (three-way contract) that receive a prospective, blended payment to provide enrolled Duals with coordinated care.

The Financial Alignment Initiative is designed to better align the financial incentives of Medicare and Medicaid to provide Duals with a better health care experience. All state demonstrations under the Financial Alignment Incentive are evaluated to assess their impact on beneficiary care experience, quality, coordination and costs. California is testing the capitated model.

Coordinated Care Initiative

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI) with the goals of enhancing health outcomes and beneficiary satisfaction for low-income seniors and persons with disabilities (SPDs), including Duals, while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. Working in partnership with the Legislature and stakeholders, the administration enacted the CCI through Senate Bill (SB) 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), and SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013).

The three major components of the CCI are:

- 1) A three-year Duals Demonstration Project (Cal MediConnect - California's Financial Alignment Demonstration) for Duals that combines the full continuum of acute, primary, institutional, behavioral health, and home and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system comprised of Medicare-Medicaid Plans (MMPs).
2. Mandatory Medi-Cal managed care enrollment for Duals; and
3. The inclusion of the Long Term Services and Supports (LTSS) as a Medi-Cal managed care benefit for SPD beneficiaries who are eligible for Medi-Cal only,

and for SPD beneficiaries who are Duals.

Enrollment in the CCI began on April 1, 2014, in accordance with the implementation schedule titled, "CCI Enrollment Timeline by Population and County," which can be found at the following link: <http://www.calduals.org/wp-content/uploads/2014/11/CCI-enrollment-by-County-11.20.14.pdf>.

Cal MediConnect

Through Cal MediConnect, Duals have access to better, more coordinated care, in addition to dental, vision, and non-emergency transportation services. The Department of Health Care Services (DHCS) and CMS contract with MMPs that oversee and are accountable for the delivery of covered Medicare and Medicaid services for Duals in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

MMPs are responsible for providing a comprehensive assessment of Duals' medical and behavioral health, LTSS, and functional and social needs. Duals and their caregivers work with an interdisciplinary care team (ICT) to develop person-centered, individualized care plans (ICPs). Cal MediConnect is designed to offer opportunities for Duals to self-direct services, be involved in care planning, and live independently in the community.

Cal MediConnect includes beneficiary protections that ensure high-quality care is delivered. CMS and DHCS have established a number of quality measures relating to beneficiary overall experience, care coordination, and fostering and supporting community living, among many others.

Memorandum of Understanding and the Three-Way Contract

DHCS executed a Memorandum of Understanding (MOU) with CMS on March 27, 2013. The MOU provides federal authority and outlines the parameters for implementing Cal MediConnect.

Many of the specific requirements are outlined in the three-way contracts between the state, CMS, and the MMPs in each CCI county. These three-way contracts require MMPs to offer quality, accessible care and to improve care coordination among medical care, behavioral health, and LTSS to eligible Duals. DHCS and CMS developed a three-way contract for each participating MMP, including a contracting process that ensures a coordinated program operation, enforcement, monitoring, and oversight. The three-way contract includes provisions for CMS and DHCS to evaluate the performance of the primary-contracted MMP and sub-contracted plans. MMPs are held accountable for ensuring that sub-contracted plans meet all applicable laws and requirements.

The three-way contract and MOU can be found at:

<http://www.calduals.org/implementation/cci-documents/cci-fact-sheets/contracts-mous/>.

Evaluation Activities of Cal MediConnect

Annual Evaluation Report

CMS contracted with Research Triangle Institute (RTI) International to monitor the implementation of demonstrations under the Financial Alignment Initiative, and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation and state-specific evaluations. RTI International's Annual Evaluation Report describes the state-specific evaluation plan for the California demonstration as of July 9, 2014. This report can be accessed at the following link: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAEvalPlan.pdf>.

The goals of the evaluation are to monitor demonstration implementation, evaluate the impact of the demonstration on the beneficiary experience, monitor unintended consequences, and monitor and evaluate the demonstration's impact on a range of outcomes for the eligible population as a whole and for subpopulations (e.g. people with mental health and/or substance use disorders, LTSS recipients, etc.). To achieve these goals, RTI International has been collecting and will continue to collect throughout the demonstration qualitative and quantitative data from DHCS each quarter; analyze Medicare and Medi-Cal enrollment and claims data, conduct site visits, beneficiary focus groups, and key informant interviews, and incorporate relevant findings from any beneficiary surveys conducted by other entities.

Implementation and Ongoing Monitoring

The CMS contractor, the National Opinion Research Center (NORC) at the University of Chicago, receives data on behalf of CMS from all MMPs. NORC is responsible for ensuring that the data received from MMPs is submitted in accordance with federal and state-specific reporting requirements. NORC checks the data submitted based on edits and validation checks that were developed for each Core and state-specific MMP measure. DHCS will publish a CCI dashboard based on the data in late 2016.

Dual Eligible Plan Choice Report

CMS is undertaking several initiatives to more effectively integrate Medicare and Medicaid coverage and improve the experience for Duals. CMS contracted with L&M Policy Research (L&M) to conduct several rounds of research to gain insight into beneficiaries' understanding of, and reactions to, MMPs and passive enrollment. The first round of research was conducted in Los Angeles and Long Beach, California in May 2014. It explored how Duals understood and used Cal MediConnect notices, the plan choice guidebook, and enrollment forms to make health plan decisions. L&M interviewed a total of 40 Duals, caregivers, and information intermediaries. While most beneficiary participants understood that the way they were receiving their health care was changing, few were clear about what was changing and how they would be affected by the changes. Participants found the concepts of passive enrollment and assignment to an MMP as well as associated deadlines and required actions confusing.

When weighing their options, nearly all Dual participants said they would determine which options and associated MMPs were accepted by their doctors before making a decision. They also wanted to know more about specific benefits that each MMP offered. Some wanted to know how much each MMP would cost.

In the fall of 2014, L&M conducted research in Illinois and Virginia, and after receiving the findings from this research, CMS requested that a similar study be conducted in Los Angeles County, California in February 2015 for beneficiaries who opted out of Cal MediConnect about one month after their scheduled January 1, 2015 enrollment date. The full findings of this research can be found in Attachment A titled, “Dual Eligible Plan Choice Research, Final Topline Report,” by L&M Policy Research.

The SCAN Foundation Funded Evaluations

The SCAN Foundation (TSF) funded two evaluations of the Cal MediConnect program: a Rapid Cycle Polling Project and a longer-term University of California Evaluation of Cal MediConnect, as described below. While TSF has funded these evaluations, DHCS is working collaboratively with TSF and stakeholders to develop the content of both evaluations.

Rapid Cycle Polling Project

TSF contracted with Field Research Corporation (FRC) to conduct a Rapid Cycle Polling Project, which is a series of rapid cycle polls to quantify the impact of Cal MediConnect on California’s Dual population in as close to real time as possible. To date, FRC has completed two waves of the project and is planning to conduct additional waves in 2016.

The study compares the levels of confidence and satisfaction of Cal MediConnect enrollees with Duals who are eligible for Cal MediConnect but are not participating, or live in a non-Cal MediConnect county within California. The survey waves are conducted by telephone with approximately 2,500 Duals or their proxies across five California counties participating in Cal MediConnect – Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara—and two non-Cal MediConnect counties, Alameda and San Francisco.

The first two waves of the project have found that large majorities of Cal MediConnect enrollees express satisfaction and confidence with their health care services and those Cal MediConnect enrollees are no more likely than other Duals to report problems with their health care services. In terms of the population that has chosen to opt out of the program, the main reasons given for not participating in Cal MediConnect relate to beneficiaries’ resistance to change.

The complete content of the most recent survey findings can be found at:
http://www.thescanfoundation.org/sites/default/files/field_research_medicare_medical_polling_results_2_12-7-15.pdf.

University of California Evaluation of Cal MediConnect

In 2014, an evaluation team comprised of researchers from the University of San Francisco Institute for Health and Aging and the University of California, Berkeley School of Public Health, designed a three-year evaluation of the CCI. The evaluation team engaged stakeholder input and built upon the national evaluation, and developed, pilot tested, finalized data collection instruments, and obtained approval from California's Committee for the Protection of Human Subjects.

This California-specific evaluation focuses on the coordination of three types of health care: medical, behavioral, and LTSS. Data collection includes:

- 1) Interviews and/or focus groups with beneficiaries representing several subgroups of interest;
- 2) Interviews with key stakeholders in each county including plans, providers, and community-based organizations that serve Duals; and
- 3) A representative telephone survey of beneficiaries to assess the prevalence of experiences with the transition and access to care, and the quality of services in their new plan.

While this evaluation is still underway, the report of the first year findings was presented at the SCAN Foundation LTSS Summit on October 27, 2015. This report discussed the results from 14 focus groups (plus interviews) with beneficiaries and 10 interviews with seven Cal MediConnect MMPs.

The focus groups revealed that many problems beneficiaries experienced in the beginning of the program have been solved over time; there is a very high satisfaction rate with care coordinators; there is better communication among providers and between the plans and beneficiaries; and more streamlined services. However, there were also discussions regarding problems with referrals and lack of understanding about the opt out process.

Interviews with the MMPs acknowledged challenges with:

- Beneficiary outreach and notification;
- Working with long term care facilities for the first time;
- Data sharing across HCBS agencies;
- Reporting requirements;
- Accessible and affordable housing;
- Steep learning curve for HCBS services and social care;
- Uncertain financial risk for taking on LTSS;
- Pressure between showing cost savings and making more investments; and
- Provider and beneficiary trust.

Although MMPs revealed these challenges, they also explained innovative practices they developed during the first year of Cal MediConnect to help address those challenges, such as:

- Satellite offices to make care coordination more local;
- One “prime contact” vs. team approach;
- Transitional care programs: hospital or skilled nursing facility to community;
- Dementia training for care managers;
- Durable medical equipment providers who do home assessments during drop off;
- Non-credentialed care coordinators as an “extender” of a nurse or social worker, and who are often bilingual;
- Impromptu or virtual ICTs; and
- Specialized care coordinators.

The MMPs also described the following care plan options that they provide:

- Cleaning and organizing apartments;
- Preparing meals;
- Interim personal care services;
- Home improvement-grab bars, ramps, widened doorways, appliances; and
- Respite for caregivers.

The full content of this evaluation titled, “The University of California Evaluation of Cal MediConnect, the SCAN Foundation LTSS Summit,” can be accessed at the following link:

http://www.thescanfoundation.org/sites/default/files/uc_evaluation_of_cal_mediconnect_carrie_graham_10-27-15.pdf.



Dual Eligible Plan Choice Research
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EXECUTIVE SUMMARY

Background and Methods

L&M Policy Research conducted in-depth interviews with 24 participants who were dually eligible for Medicare and Medi-Cal on February 17-18, 2015 in Los Angeles, California, to find out why dual eligible beneficiaries are opting out of the Cal MediConnect Medicare-Medicaid Plans (MMPs). All beneficiary participants currently have Original Medicare and fee-for-service Medi-Cal.

Key Findings

Major factors for opting out. Most dual eligible participants opted out of Cal MediConnect to ensure continuity of care and access to their doctors. Other reasons most often cited by participants for opting out, in order of priority, included:

- Maintaining provider access and freedom to direct care. This included a desire both to:
 - Continue seeing current providers, and
 - Preserve the freedom to choose future doctors and hospitals and see these providers without restrictions such as referrals;
- An interest in keeping their coverage as close as possible to the coverage they previously had, which was influenced by both an:
 - Understanding that opting out was the closest option to keeping their current coverage and ensuring access to their providers;
 - Inability to weigh advantages of MMPs against current coverage;
- Negative attitudes about and past experience with government programs and expectations that the passively assigned plan would reduce costs at the risk of lowering quality.

Decision-making behaviors. Three types of decision makers emerged during interviews with participants:

- Proactive – those who understood their options and the consequences of their (in)action and took steps to opt out of their passively assigned MMP;
- Reactive – those who opted out of their passively assigned Cal MediConnect plans based on a reaction to an experience at their doctor's office;
- Inactive – those who did not recall making a decision about their current coverage and were unsure how they came to be enrolled in their current plans.

Impressions of MMPs. Some participants named a few advantages related to the Cal MediConnect plans, including dental services, transportation, and care coordination. Participants did not perceive these benefits as outweighing potential risks of losing access to their long-standing doctors, increasing costs, and reducing quality. These participants were unwilling to risk current coverage benefits when they had little knowledge about the impetus for development

of the Cal MediConnect initiative, the MMP, and the added value provided by its additional benefits.

Use of information sources. Most participants remembered receiving the Cal MediConnect communication materials. They were aware that they needed to make a decision and take action to avoid being passively enrolled into an MMP. All of the participants recalled speaking with someone: their doctors, the state customer service line (Healthcare Options), Medicare, their current plan, and/or their passively assigned MMP. A few participants mentioned receiving information from advocacy organizations, which they reported did not significantly influence their decision to opt out.

INTRODUCTION AND METHODOLOGY

Background

The Centers for Medicare & Medicaid Services (CMS) is undertaking several initiatives to more effectively integrate Medicare and Medicaid coverage and improve the experience of those individuals enrolled in both programs, also referred to as Medicare-Medicaid enrollees or dual eligible beneficiaries. State Medicaid programs and the federal Medicare program have partnered to launch a three-year demonstration called the *Medicare-Medicaid Financial Alignment Initiative* to promote coordinated health care delivery to seniors and people with disabilities who are dually eligible for both of the public health insurance programs.

CMS is testing two models of care. The models include a capitated model and a managed fee-for-service (FFS) model. In the capitated model, dual eligible beneficiaries are enrolled in a single health plan covering all of their Medicare and Medicaid benefits. CMS is testing the capitated model in several states, including California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, and Virginia. In the FFS model, a state and CMS enter into an agreement by which the state would be eligible to benefit from a portion of savings from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

Some states participating in the capitated model have incorporated both opt-in and automatic (also known as passive) enrollment strategies to enroll dual eligible beneficiaries in a Medicare-Medicaid plan (MMP). In states with passive enrollment, dual eligible beneficiaries are given the opportunity to make a choice to opt out of the assigned MMPs. Otherwise, they will be automatically enrolled in an MMP. CMS requires states with passive enrollment to provide beneficiaries at least 60 days' notice of the passive enrollment and to send multiple communications regarding passive assignment to an MMP.

CMS contracted with L&M Policy Research (L&M) to conduct several rounds of research to gain insight into beneficiaries' understanding of and reactions to the MMPs and passive enrollment. The first round of research was conducted in Los Angeles and Long Beach, California in May 2014. It explored how dual eligible beneficiaries understood and used demonstration notice letters, a plan choice guidebook, and book and enrollment form to make health plan decisions. L&M interviewed a total of 40 dual eligible beneficiaries, caregivers, and information intermediaries. While most beneficiary participants understood that the way that they were getting their health care was changing, few were clear about what was changing and how they would be affected. Participants found the concepts of passive enrollment and assignment to an MMP as well as associated deadlines and required actions confusing.

When weighing their options, nearly all dual eligible beneficiary participants said that they would determine which options and associated plans were accepted by their doctors before making a decision. They also wanted to know more about the specific benefits offered by each plan. Some also wanted to know how much each plan would cost before making a decision.

In the fall of 2014, L&M conducted research in Illinois and Virginia to understand beneficiaries' decisions to opt out, disenroll from, or switch between demonstration plans. All participants considered provider choice and access key factors when making a decision about coverage.

Almost half of the participants sought more information and attempted to make a decision to opt out or switch before the effective enrollment date of their passively assigned plan. These beneficiaries turned to their passively assigned MMPs, state Medicaid offices, and their doctors' offices for information and advice. Participants reported doctors' offices and MMPs provided little information about the demonstration in general and were not in a good position to help them compare all of their options. Participants in Illinois and Virginia did not report any proactive, provider-initiated communication about the demonstration. Participants noted MMPs were sometimes unclear, and in two cases misleading, about whether or not the provider participated in the MMP's network.

After receiving the findings from Illinois and Virginia research, CMS requested that a similar study be conducted in Los Angeles County, California in February 2015, for beneficiaries who opted out about one month after their scheduled January 1, 2015 effective enrollment date. Los Angeles County began enrolling beneficiaries who opted into the MMPs in April 2014 and initiated the first wave of passive enrollment in July 2014. Compared to other demonstration states, California has a significantly higher opt-out rate; according to January 2015 enrollment data, about 50 percent of those who have been passively enrolled have opted out or disenrolled in Los Angeles County.¹ CMS requested that the research focus specifically on dual eligible beneficiaries who opted out of Cal MediConnect before the January 1st effective enrollment date.

Research objectives

The overall research objective for the study was to understand how beneficiaries make decisions about opting out from their passively assigned MMP. Research questions included:

- Why did beneficiaries opt out from their passively assigned plan?
- What decision-making process did beneficiaries follow in deciding to opt out?
- What were the main factors that influenced their decision to opt out from their passively assigned MMP?
- How did beneficiaries hear about the demonstration?
- What impressions did beneficiaries have of the MMPs?
- What materials or information did they use, if any, to assist in their decision?
- Where did or from whom did beneficiaries look for additional information?
- What, if any, information did they want but didn't have that would have helped them in their decision?

¹ <http://www.calduals.org/wp-content/uploads/2015/01/CMC-Enrollment-Dashboard-Jan-2015-FINAL.pdf>

Methodology

In January 2015, CMS provided L&M with names, addresses, and health plan information for individuals who had opted out of their passively assigned plans. L&M then provided password-protected lists to market research facilities to recruit research participants. CMS approved and L&M drafted the recruitment screeners.

L&M conducted interviews with 24 dual eligible beneficiaries on February 17 and 18, 2015 in Los Angeles, California. L&M sought diversity in age, gender, race/ethnicity, and level of education. Table 1 describes demographic characteristics for the participants.

Table 1. Participant Demographics

Category	Type	Number of Participants
Age	Under 65	13
	65 and older	11
Gender	Male	12
	Female	12
Race/Ethnicity	African American	9
	Caucasian	10
	Hispanic/Latino	4
	Asian	1
Level of Education	Less than high school graduate	2
	High school graduate or GED	6
	Some college	14
	College graduate	2
	Post graduate	0

L&M developed a draft interview protocol, which CMS reviewed and approved, to guide the in-depth interviews. Interviewers first collected information on the participants' current health care plan cards. Then they used a timeline exercise to discuss awareness of the demonstration and the decision-making process participants used to opt out of their passively assigned plan.

RESEARCH RESULTS

The following section describes key themes that emerged during the interviews,² beginning with a discussion of decision-making factors that led to opting out, followed by an exploration of how beneficiaries with different decision-making behaviors weighed those factors.

Major factors for opting out

Provider access and freedom to direct care

All participants voiced provider access as the most important factor and frequently cited it as the basis for opting out of passively assigned Cal MediConnect MMPs. This included an interest in both maintaining access to specific providers and maintaining the freedom to choose providers in the future.

Many participants indicated they needed care for one or more chronic conditions and had long-standing, trusted relationships with one or more doctors. They viewed continued care from the same providers as a critical priority. For many beneficiaries that meant opting out of the Cal MediConnect program entirely. Either they knew their providers were not participating because they actively inquired on their own or received provider-initiated communication, or they assumed a change in benefits would mean a change in their ability to access their providers but did not inquire or communicate with providers to confirm. (Provider communications are discussed in more detail within the “Information Sources” section of the report.)

Some participants decided to opt out not only to ensure that they could continue to see their current doctors but also to allow them to choose future providers and direct their own care. These participants seemed philosophically opposed to the limits the MMP would impose on their freedom. Even if these participants found an MMP that accepted all of their current doctors, they did not want to be subject to network restrictions or referral requirements that enrollment in the MMP would entail.

Satisfied with current coverage and risk averse

Many participants said that they did not want to change their coverage to Cal MediConnect because they were satisfied with their current coverage and they wanted to keep it. Original Medicare and Medi-Cal allowed them to see their preferred providers and an affordable, low-cost prescription drug benefit. They characterized Cal MediConnect as a risky choice especially when they did not know or understand the differences between Cal MediConnect and their current coverage. They expressed risks as including losing their current doctors, increased costs, and not getting the care that they needed.

Some participants were able to name some key differences between plan types (e.g., referral processes, dental and vision benefits, care coordination). However, many said that these

² Given the limited, qualitative nature of the research, it would be both inaccurate and misleading to discuss findings in statistical terms. Accordingly, we use approximate terms – most, many, some, few – to indicate the number of participants who expressed a given view, rather than numbers or percentages.

additional benefits, while valuable, could not outweigh their need for continuous care from their preferred providers. Without a fail-safe guarantee that they could see their doctors and a clear understanding of the benefits of the Cal MediConnect plan, participants said that they preferred to keep their existing coverage. A few participants said that they would be willing to consider Cal MediConnect if they understood the differences between options well enough to weigh the risks against the benefits.

Participants seemed to generally understand that choosing the option to keep Original Medicare, including a Medi-Cal plan, would keep their coverage as close to the same as possible. In California, individuals who keep Original Medicare must make a second decision to choose a Medi-Cal managed care plan. It appeared that some participants did not put much effort into the decision about the Medi-Cal plan once they decided to opt out of Cal MediConnect altogether. Participants had the sense that, because Medicare is primary, the decision between Original Medicare and the MMP had a more significant impact on their benefits and care than the decision among their Medi-Cal plan options.

It is important to note that in this market, Caremore is the only brand that does not offer both an MMP and a Medi-Cal plan. Care 1st, Health Net, LA Care and Molina offer both MMPs and Medi-Cal plans, often in partnership with each other when offering the Medi-Cal option. For many participants who did put effort into the Medi-Cal decision, the Medi-Cal plan choice requirement was somewhat confusing because of brand crossover between MMPs and Medi-Cal offerings. However, it is worth noting that participants did not consider the Medi-Cal plan choice requirement a barrier to opting out of Cal MediConnect. By choosing to keep Original Medicare, including a Medi-Cal plan, participants felt that they would keep their coverage as close to the same as possible.

Negative attitudes toward government programs, passive enrollment and cost reduction

Many participants had negative reactions to passive enrollment. They indicated feeling the government was imposing its will on their decision. They also voiced concern that passive enrollment negatively impacts the quality of their care. Many participants expressed that the enrollment letters clearly conveyed that the government would choose for them if they did not choose for themselves. Some stated they believed a plan selected by the government would be inferior to a plan they would choose for themselves; as a result, they were highly motivated to consider other options. One participant said that he assumed the government would give him fewer services and higher copays. Many had questions about the impetus for this new, government-directed change in their benefits; without knowing why Cal MediConnect was created, one participant suspected that the government had a “hidden agenda” and presumed that the plan assignment was cutting costs at the risk of reducing quality of care.

It appeared that one participant misunderstood the notice letter and thought that she was at risk for losing her Medi-Cal benefits, which prompted her to call Healthcare Options to opt out. Her case was unusual compared to other participants. Most who remembered receiving Cal MediConnect communications understood they would be able to continue to receive Medi-Cal benefits and focused instead on potential changes in provider access and costs if they enrolled in Cal MediConnect.

Decision-making processes and behaviors

Participants' self-reported decision-making behaviors displayed a range of awareness, understanding, and action. Researchers observed three trends in participants' decision-making behavior:

- *Proactive*
- *Reactive*
- *Inactive*

Proactive decision makers

Proactive decision makers recalled receiving Cal MediConnect communications, understood their options and the consequences of their (in)action, and proactively took steps to opt out of their passively assigned Cal MediConnect plan. More than half of the participants opted out of their passively assigned plan either soon after receiving MMP communications or close to the deadline but after seeking additional information.

Of these participants, a few were somewhat “on the fence” about their decision. They indicated perceiving some added value to enrolling in an MMP but were risk averse to making changes to their current health care coverage. Another participant said he thought the MMP “might have been better,” but because he was satisfied with his coverage at the time, he did not see a reason to change it. Most of these proactive decision makers contacted their current plans, their passively assigned MMPs, the state (Healthcare Options), their doctors and/or friends for information. Most said they made their decision to opt out after verifying that they could not continue seeing their doctors; a few, however, either assumed they would lose access to their providers or merely “did not want to take the chance.”

John's proactive decision to opt out

John is a 59-year old dual eligible beneficiary who has been seeing his UCLA primary care physician for over 20 years. He proactively sought out information from multiple sources and clearly remembered receiving the Cal MediConnect communications. His first priority in making his decision was to ensure that he could continue his long-standing relationship with his provider without incurring additional costs. When asked to describe Cal MediConnect, John said that it was a managed care plan where “everything is coordinated by a coordinator” that offered extra services, which he considered an advantage of participating in Cal MediConnect.

Prior to making his decision, John called Healthcare Options several times and talked to his doctor's office and LA Care. He also may have talked to a patient advocate at the Center for Healthcare Rights, but it was unclear to him if the person who assisted him was from Healthcare Options or the Center for Healthcare Rights. This representative talked through a Physician's Toolkit document that he said he could show to his physician. During his initial call to Healthcare Options, a representative suggested LA Care for him; John assumed his doctor was affiliated with the UCLA healthcare system. However, when another representative from Healthcare Options or the Center for Healthcare Rights called John's doctor's office in a teleconference with John, the representative, and the doctor's office, it was unclear that John's doctor was participating in LA Care's network. While John tried to be open-minded to joining Cal MediConnect, he ultimately decided to opt out because he had no guarantee that he would be able to keep his doctors if enrolled in the MMP.

It is worth noting that a few of those who opted out delayed in taking action and demonstrated a lower level of awareness about Cal Medi-Connect compared to the others. These participants remembered seeing some communication about the demonstration. Although they could not clearly articulate specific details, they seemed to understand they had to take some action to avoid being enrolled in the MMP. These participants waited to take the necessary steps to opt out

James' delayed decision to opt out

James is a 65-year old dual eligible beneficiary who did not recall receiving any communication about the Cal MediConnect program. He was delayed in opting out and appeared to have a lower level of awareness than other proactive decision makers. James found out about a potential change in his benefits when someone at a county office told him that he had to make a choice. He chose LA Care's MMP; he had an LA Care plan two years prior to the Cal MediConnect rollout. He was then assigned providers who practiced several cities away and were inconvenient, which triggered James to change his plan. Despite not understanding the Cal MediConnect process, he persistently visited the LA Care facility several times to make changes to his benefits so he could see doctors that were conveniently located in his neighborhood. His persistence resulted in opting out of Cal MediConnect and enrolling in Original Medicare with an LA Care Medi-Cal plan.

until close to the deadline. One simply forgot that a deadline was looming; another participant waited until he got advice from his doctors; and the other participant did not clearly understand what he was opting out of but knew he wanted to do whatever was needed to have a choice, “so I could see the doctors that I want.”

Reactive decision makers

These participants indicated they opted out of their passively assigned Cal MediConnect MMPs based on a reaction to an experience at their doctor, mainly in discovering that their provider(s) do not participate in their passively assigned Cal MediConnect plan’s network.

Less than a third of participants opted out of their passively assigned MMP based on a reaction to an experience at their doctor’s office, where they discovered that their provider(s) did not (or were not going to) participate in their passively assigned MMP network. Interested in the additional benefits his passively assigned MMP was offering, such as transportation, dental, and vision, one participant enrolled in that plan in the fall. Later that month, the participant discovered that one of his providers did not participate in that plan’s network, which prompted him to disenroll. Another participant stated she only realized that she was enrolled in an MMP when she was told that a scheduled elective surgery would not be covered. This participant said she then called a 1-800 number (presumably Healthcare Options) to opt out. Another participant reported being told numerous times by his passively assigned MMP that his providers would be signing up for the MMP. This participant explained he was very frustrated when he discovered his doctor, in fact, was not participating in the MMP’s network.

Intense provider involvement in reactive opt-out decisions

It is worth noting that a few of these who made reactive decisions to opt out received an intense level of assistance from their doctors in understanding their options, making a decision, and opting out of their passively assigned MMP. One participant reported his cardiologist alerted him that he would be getting information in the mail about changes and recommended keeping his coverage as it currently was. The participant also reported that staff from the cardiologist’s office assisted him in disenrolling from his passively assigned MMP.

Jeffrey's reactive decision to opt out

Jeffrey, a 52-year old dual eligible beneficiary, has received health benefits for over 20 years due to a disabling chronic disease. He remembered receiving a Cal MediConnect letter and materials in the mail. He was initially very frightened by and depressed about the possibility that he would not be able to see his long-time doctor and might have to forgo healthcare services.

Jeffrey initially chose the HealthNet Cal MediConnect plan because it “seemed like the lesser of the evils”. Of the other choices, he felt the plan was more established, provided more comprehensive services including dental care. When he asked HealthNet if his provider was in-network, he was told that his provider was “going to be on the list but we don’t have him registered yet”.

After enrolling in the HealthNet MMP, Jeffrey went to see his primary care physician and talked to him about his recent enrollment. His doctor said, “I wish you had spoken to me [because] I want to continue your care” and informed Jeffrey that he was not participating in the plan. He felt betrayed by HealthNet because his doctor was not in their network, and immediately called to opt out. He joined the LA Care Medi-Cal plan on the advice of his doctor.

Another participant stated that his psychiatrist “adamantly said not go into Cal MediConnect.” During an appointment, the participant said his psychiatrist called to opt him out of his passively assigned MMP and enroll him into a Medi-Cal plan. While the participant thought this was helpful initially, it became problematic because the participant had other providers that he also needed to see who did not take that particular Medi-Cal plan. This required a second change in his health plan to LA Care, based on his primary care physician’s advice (please see “Intense

Intense provider involvement in Robert's decision to opt out

Robert, a 52-year old dual eligible beneficiary, sought help from his doctors after he received his Cal MediConnect letter. He initially saw his psychiatrist, who advised him to join HealthNet. During the appointment, his psychiatrist called Healthcare Options to opt him out of the Cal MediConnect plan and enroll into the HealthNet Medi-Cal plan. The following week, Robert went to see his primary care physician, who told him to enroll in LA Care, because he did not participate in HealthNet.

Robert’s primary care physician’s office called Healthcare Options and helped enroll Robert in LA Care. Afterwards, Robert had to call his psychiatrist to make sure that she took the LA Care Medi-Cal plan. He felt that he was “being whipped around” in a difficult process that required him to go from provider to provider in order to coordinate his coverage.

provider involvement in Robert’s decision to opt out” above). Many dual eligible beneficiary participants required care from multiple providers who were not always members of the same healthcare system. For these participants, it was critical to coordinate with multiple providers in order to make a decision that would lead to the most comprehensive coverage while maintaining access to the care that they needed.

Inactive decision makers

Several participants did not recall making a decision about their current coverage and were unsure how they came to be enrolled in their current plan. One of these participants recalled receiving some communications about the demonstration while the others did not. This participant remembered getting something in the mail, but because he did not understand what it was saying, he did not call or talk to anyone because he did not know what to ask.

In general, these participants had great difficulty recalling the actual steps they took and when. However, there were a couple of participants who were simply confused about the program. They were not able to remember or articulate what they thought about the potential change and could not explain their decision. These participants cared about their healthcare coverage and were inquisitive about Cal MediConnect during their interviews but had not found the current forms of communication effective.

Impressions of the MMPs***Perceived disadvantages***

Participants had varying impressions of the MMPs. However, most perceived these new plans as limiting their health care choices and options, both in terms of ability to see their current doctors and access services. Specifically, many participants indicated they were concerned about losing access to their existing doctors or having limited choice in doctors. A few were also concerned about their services being limited if, for example, they had to receive prior approval for a particular service. One participant seemed to form her perceptions based on rumors she had heard that MMPs limit their member access to only one doctor.

“It seemed like finding a doctor that would accept that coverage would be far and few in between and that you would have to get prior approval, which takes time, and overall it just looks like they would be having me running around town to get services.”

[What would have happened to your coverage if you had been enrolled in a plan?] “It would be so terrible if I can only go to one doctor. I have so many different ailments. I didn’t want this to happen and that’s all I knew.”

“The consensus that I came to was that if you were placed into HMO or something like that you were limited to one doctor and I didn’t want that.”

As noted in the discussion regarding major decision factors for opting out, some participants perceived the MMPs to be government plans and, therefore, not to their advantage. These participants described the government “bundling” their Medicare and Medicaid together, which could result in a loss of some services or services rendered at a potentially higher cost to the beneficiaries. These participants did not want the government to choose a plan for them.

“Well if it is coming from the government then it is probably not to our advantage. It sounds like they want to take us off Medicare and bundle everything together and when you bundle things together, it seems that you will miss

services. It seems that they are changing it to be more copays and less benefits - that was my assumption of how the government is.”

“I thought it was not private industry because the government was suggesting it. And at the time I associated Anthem with private industry and that to be better. I didn’t want them (the government) to choose for me.”

In addition, one participant had had a negative experience with one of the insurers before it offered a Cal MediConnect plan, which made her very distrustful of the program. Another was skeptical of being automatically enrolled or automatically assigned to an MMP plan. This participant seemed to have had a similar experience in the past when she had been automatically enrolled in a managed care plan.

“MediConnect, they are like HealthNet. You have to go to their doctors, which are horrible. I had HealthNet before and it was the worst and I couldn’t believe it. I couldn’t go to any doctors unless they sent me to them. I had to wait for an appointment for specialists, and I got an infection they didn’t treat. I made a court case to try to get my [straight] Medi-Cal back.”

“And the idea of someone ‘automatically’ putting me in something, I don’t like. This is my healthcare. Medi-Cal has done that before. [If they did it this time] then I’d have to call and make changes again.”

Perceived advantages

A few perceived the MMPs to be potentially favorable or advantageous compared to their current coverage. For example, one participant liked the idea of having additional benefits, such as transportation or dental care.

“And they even made it sound better – that they would set up transportation now, to and from appointments. And that was really nice because I don’t have a car, so I was interested in that.”

A few also expressed interest in the notion of having *coordinated care*. However, most of them did not really understand what coordination of care meant or how it would be beneficial to them. A few participants who were especially engaged in coordinating their own care said that they did not need someone else to do so.

Overall, even when participants perceived a new or added benefit in the MMPs, these added benefits were not important enough to actually make changes to their existing coverage. A couple of participants, for example, were open to the idea of participating in Cal MediConnect, but both ultimately decided to opt out because “there is no guarantee” they would be able to keep their doctors and not have to pay more for services than they are paying now. For these participants, the perceived benefits did not outweigh the perceived risks.

[Have you heard of combined/coordinated (demonstration) plan?] “Yes, but, I just want to continue to do what I was doing because it was working for me. What I have now is working.”

[What is Cal MediConnect?] “It’s a type of managed care where everything is coordinated by a coordinator. It could be a good thing for some people but not necessarily good for me – it might slow things down. I like to make my own decisions actually – but it did interest me and some of the other services like transportation – in some situations even with what I got now it would be covered but even more so Cal MediConnect had this.”

“So it sounds good to me, the combined plans sound convenient. But until I know my therapists are part of it, I will keep what I have. If they were to switch over I think it sounds great.”

When asked if there were additional benefits or plan aspects that would have encouraged them to consider enrolling in an MMP or if there are any aspects missing from their current coverage, many participants mentioned that they simply did not want to change anything or “fix what is not broken.” These participants did not appear comfortable taking any risks or changing their current health care situations. Many of these participants have multiple and serious health conditions and consider their relationships with their providers crucial to their care.

“It’s hard to restart with someone else. I’ve switched plans before but they would switch my doctor and I would have to start my whole life again.”

“When this [my current coverage] is working, it’s not broke, so why try to break it to re-fix it!”

“If I could have been on that plan and kept my doctors the same and no extra payments then I would be open to be in Cal MediConnect. But I was going to err on the side of caution – I’m not a risk taker, especially with my healthcare.”

Information sources

Cal MediConnect written communications

For the most part, participants remembered receiving the various communications materials and were aware that they needed to make a decision and take action to avoid being enrolled into a passively assigned MMP. While most recalled receiving some type of communication from the state, few relied solely on the written materials to make their decision. All of the participants mentioned speaking with someone either by phone or in person before making their final decision to opt out of their passively assigned MMP. Participants mentioned contacting the state customer service line (Healthcare Options), Medicare, their doctors, their current plan, and/or their passively assigned MMP.

Almost all participants remembered receiving the sample 60-day notice letter. Some remembered after seeing the sample letter, particularly recalling the Cal Medi-Connect header. When asked if messages from the letter resonated with them, most participants replied that they realized that they needed to take action and do something or choose something even if they were unclear of the exact changes to their healthcare. While the phrase telling participants that they “must” choose a plan almost always got their attention, many were discomfited by the notion that they

were being forced to do something. Several participants explained that the phrase made them angry because they were pleased with their current coverage and felt it was being taken away.

“When I see “Must” or “You Must Choose” that makes me angry because I am content with how things are for me and if you tell I must choose then I know I am going to run into some problems. If I choose this side I am missing something from this side and vice versa. And I like what I have, my Medi / Medi and I don’t want to have to choose, I want to stay with what I have.”

Dependent on receiving timely health care services and unsure about what was happening, other participants described feelings of fear or anxiety after receiving the letter. One woman even remembered hearing that she could lose her Medi-Cal benefits if she did not do something.

“The main thing (in the letter) was if you don’t call and do something about the situation, it is possible you will lose your Medi-Cal.”

“If I didn’t go with something, they would assign us to something. That was kind of scary – no other word to explain it – it was scary.”

Communication with providers

Communications with individual doctors and larger provider networks greatly influenced participants’ decisions to opt out of Cal MediConnect. These providers were typically primary care physicians or specialists or their office staff. Some participants mentioned insurance specialists, one associated with a local hospital and another with an HIV clinic.

Interviews revealed a spectrum of provider involvement. This included a low level of involvement, such as providing information about Cal MediConnect changes, answering patients’ questions about plan participation, and leaving flyers in their waiting room about the Cal Medi-Connect program. A high level of initiation, involvement, and guidance included provider-initiated communication, such as letters and telephone calls, giving information about changes in benefits during office visits, advising the patient which plan to choose, and making the call to Healthcare Options for the beneficiary to opt out.

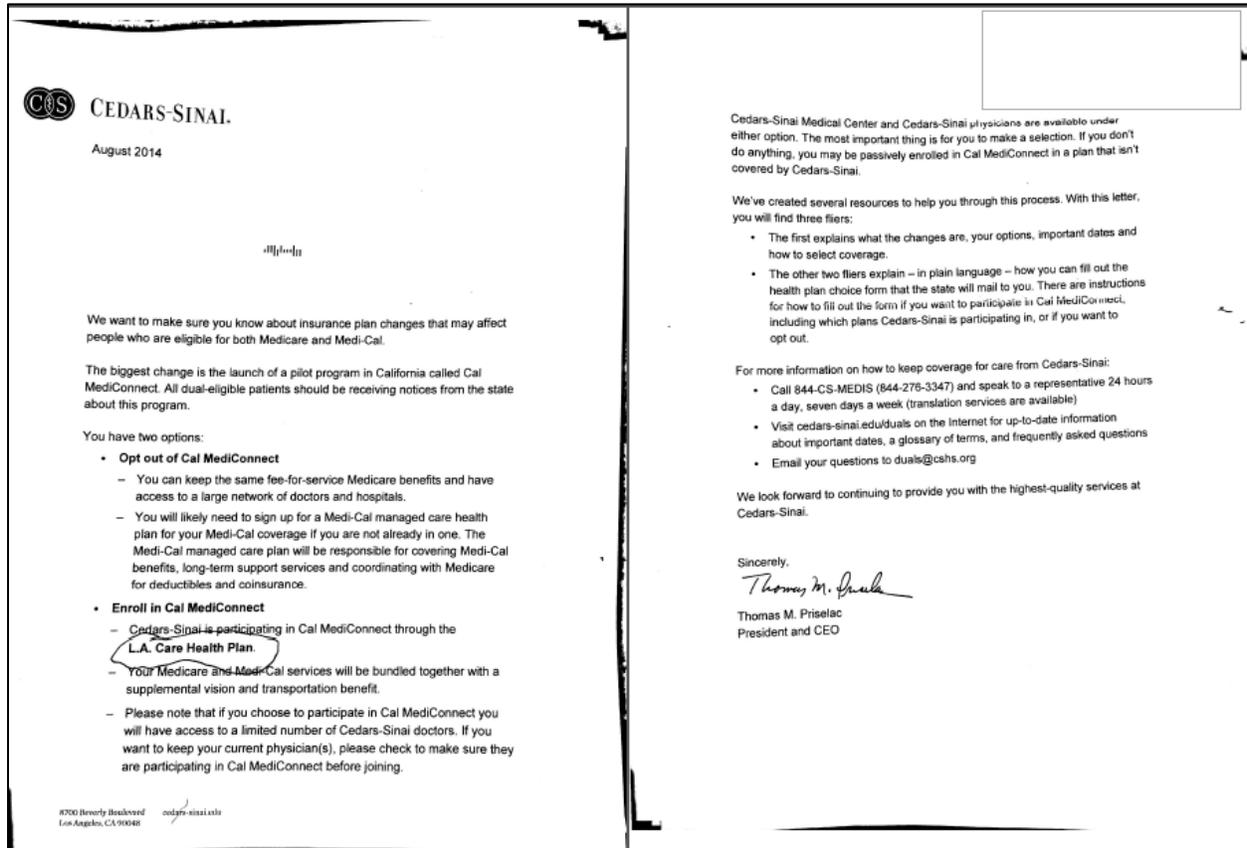
Beneficiaries often initiated communications with providers. They indicated reaching out to their doctors to ask which plans would allow them to continue their care. But some doctors or providers proactively contacted the participants and told them that their coverage would be changing and to expect information in the mail.

“The doctor told me out of the blue that I would be receiving some kind of information in the mail about my medical coverage. And that in order to remain where I was in the system to bring it in and they would help me fill it out.”

Many participants’ primary care and specialist physicians practiced in community clinics, academic medical centers, and large private hospital networks. A few academic medical centers and a large private hospital network provided beneficiaries with information and assistance that influenced them to opt out. Several participants received correspondence from their hospital system that provided information about Cal MediConnect and plan participation. One participant

brought in a letter (see Figure 1) that he received in August, one month before the scheduled delivery of the Cal MediConnect 90-day notice letter.

Figure 1. Provider correspondence regarding Cal MediConnect



Calls to Cal MediConnect and Healthcare Options

Participants who called Cal MediConnect and Healthcare Options experienced varying degrees of satisfaction with the experience and information received. One participant described discussing her upcoming treatment with a representative from Cal MediConnect, who recommended that she opt out of the Cal MediConnect plan to avoid the risk of treatment disruption. However, another participant talked about calling the Cal MediConnect phone number to get more information and feeling as if the representatives did not know the specifics about the program and were not able to give her enough information.

[How helpful was MediConnect?] “Not helpful, they sounded like it was new to them as well!”

Communication with MMPs

Some participants called the individual MMPs for more information, and a few called the plans to opt out of their assigned plan. Participants who wanted more information did not feel that the MMPs were able to answer their questions.

“But {MMP} was not informative, I wanted to know about the network of doctors but when I was on the phone with them, they did a search, then said they were not sure, so they didn’t seem to have it together and I was skeptical.”

One participant called the MMP said that he experienced a delay in getting a call back, so he called Medicare to opt out.

“[M]y gastroenterologist, a doctor that my PCP referred me to, started having a problem with {MMP} because I got a returned appointment in September. So I went back to the primary and then they told me to call this guy [MMP representative] and it was like pulling tooth and nail and they were putting it off and now {the MMP} wasn’t returning the calls.”

Communications with friends and other patients

Several participants also mentioned talking to friends or other patients in the doctor’s waiting room. While they indicated it was sometimes comforting to talk to other patients and friends, it sometimes spread uncertainty rather than providing clearer answers.

“There were rumors going around that if you didn’t select coverage that they would place you in one automatically. And I didn’t want to be tossed into something I didn’t know anything about...If they put up in Health Net or something like, you will only be able to go to one doctor... It would be so terrible if I can only go to one doctor. I have so many different ailments. I didn’t want this to happen and that’s all I knew.”

Advice from advocates

Few participants mentioned getting advice from advocates about their decision to opt out. Two participants said that they listened in on a town hall teleconference. One said that he had already made his decision to opt out before the call, and the other said that he had trouble comprehending the discussion. One participant called the Center for Healthcare Rights, which talked him through a physician’s toolkit document (see Figure 2) that he used. This participant sought information from multiple sources and named this resource, although not major, as one factor among many in his decision to opt out.

As noted previously in the discussion regarding proactive decision making, an advocacy agency worked with one participant at length and conferenced in his physician to ensure that he would still be able to see his current providers but did not seem to push him toward a specific outcome.

Figure 2. Center for Healthcare Rights Physician Toolkit

Physician Toolkit

Providing Fee-For-Service Medicare Services to Dual Eligibles in Medi-Cal Plans

The Coordinated Care Initiative (CCI) is an effort by California and the federal government to integrate the delivery of medical, behavioral, and long-term services and supports for persons eligible for both Medicare and Medi-Cal (i.e., dual eligibles). Most dual eligibles in eight counties will be eligible to enroll in a new type of coordinated plan, called a Cal MediConnect plan. These plans will be responsible for administering the benefits under both programs. Participation in Cal MediConnect is voluntary, so people can choose to join or choose to opt out and receive Medicare services as they do today. If someone is eligible for Cal MediConnect and they don't make an affirmative choice to join or not join, they will be automatically enrolled into Cal MediConnect on their coverage date, usually the first day of their birth month. They can choose to disenroll in any month.

If your patients decide not to join a Cal MediConnect plan, they can continue to see you as a Medicare Fee-for-Service (FFS) physician. However, at the same time California is requiring most dual eligibles who do not enroll in a Cal MediConnect plan to enroll in a Medi-Cal managed care plan for their Medi-Cal benefits, including long-term services and supports. *

The state has received reports of a common but dangerous misunderstanding: patients who decide they want to continue in Original Medicare are being told they may not continue to see their existing physicians if they are enrolled in a Medi-Cal plan. This is plainly false. Patients remaining with Original Medicare may continue to see their current physicians even if they join a Medi-Cal plan. Medicare physicians do not need to be contracted with Medi-Cal plans to see dual eligible patients. This misunderstanding thwarts the patient's effort to be treated by the physician, and causes the physician to lose that patient, based on false information. See below for billing instructions. *

Financial Responsibility for Physician Services

Physician services provided to dual eligibles are the financial responsibility of Medicare, not Medi-Cal. It is a Medicare benefit paid primarily under the Medicare fee schedule. For most physician services, the rate physicians receive is 80 percent of the Medicare fee schedule.

Medi-Cal has responsibility for services and supports not covered under Medicare, including Medicare cost sharing as well as some long-term care, durable medical equipment, incontinence supplies, and other services and supports. The only role Medi-Cal managed care plans will have with respect to physician services for dual eligibles will be to adjudicate the payment of crossover claims for any Medicare cost sharing owed under California state law.

Billing for Fee-for-Service Original Medicare

If dual eligible Medicare patients decline to enroll in a Cal MediConnect plan, or are excluded from joining a Cal MediConnect plan, their physicians should bill for Medicare services exactly as in the past. Even if the patient is enrolled in a Medi-Cal managed care plan, the physician should bill for Medicare services exactly as in the past. There is no change in what Medicare Fee-For-Service will pay for billed charges, generally 80 percent of the Medicare fee schedule. *

It should be noted that no change is made in the rules governing the billing of the 20 percent co-pay for dual eligible patients. It continues to be unlawful to bill dual eligible patients.¹ Instead, that claim for the 20 percent copay should be sent to the patient's Medi-Cal plan – this is known as a "crossover claim." *

Billing Crossover Claims

In most cases, providers will need to send their "crossover claims" for the 20 percent co-pay to the patient's Medi-Cal plan, which will pay the physician any amount owed under state Medi-Cal law. In some limited cases, Medicare will send these crossover claims automatically and directly to the Medi-Cal plans. Physicians do not need to be part of the Medi-Cal plan's network to have these crossover claims processed and paid. Please refer to the "How Medi-Cal Plans Process Crossover Claims" document in this toolkit for a chart outlining how Medi-Cal plans will process crossover claims.

It should also be noted that no change is made in the rules governing how much the Medi-Cal plans will pay on these claims for Medicare services to dual eligibles. Since 1982, state law has limited Medi-Cal's reimbursement on Medicare claims to an amount that, when combined with the Medicare payment, does not exceed Medi-Cal's maximum payment for similar services.² Consequently, if the Medi-Cal rate is 80 percent or less than the Medicare rate for the service rendered, Medi-Cal will not reimburse anything on these crossover claims. If the Medi-Cal rate is higher, providers will receive the payment. For example, in 2014 many primary care providers will receive Medi-Cal reimbursement, as Medi-Cal payments for primary care services in certain circumstances have been raised to 100 percent of Medicare under the Affordable Care Act.

However, since Medi-Cal reimbursement rates are generally lower than Medicare rates (80 percent of the Medicare fee schedule), it is anticipated that there are few types of services where Medi-Cal owes any reimbursement on Medicare claims. Again, this is not the result of the Coordinated Care Initiative. This has been the rule in California for over 30 years.

¹ Welfare and Institutions Code, Section 14019.4. (a): "A provider of health care services ... shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient..."

² Welfare and Institutions Code, Section 14109.5: "Notwithstanding the provisions of Section 14109, effective January 1, 1982, the reimbursement rate for costs specified in Section 14109 for all services, including, but not limited to, hospital inpatient services, shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this chapter. For purposes of this section, effective October 1, 1992, the reimbursement rates established under this chapter for hospital inpatient services shall be no greater than the amounts paid by the Medicare program for similar services."

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CONCLUSIONS

Most participants opted out of Cal MediConnect because they wanted to keep their doctors, especially when they had long-standing relationships with their doctors due to chronic illness or injury.

- ***Providers have a strong influence over decisions:*** Communication with, and advice from, these trusted providers often influenced participants' decisions to opt out of their MMPs in order to continue their care.
- ***Proactive decision makers are risk averse:*** More than half of the participants were proactive decision makers who researched their options and talked to multiple information sources. Some were initially willing to consider Cal MediConnect but were ultimately unwilling to risk current coverage benefits when they had little knowledge about the MMP, the added value offered with its additional benefits, and the impetus for development of the Cal MediConnect initiative.
- ***Maintaining access to multiple providers is a challenge:*** A few beneficiaries with multiple providers had trouble picking a plan that would allow them to see all of their providers. Some beneficiaries had to change plans more than once because they did not communicate and coordinate with all of their doctors or because one provider advised them about a coverage decision without ensuring that plan would allow the beneficiary to see all of his/her providers.
- ***Opting out is perceived to ensure freedom of choice:*** In addition to maintaining access to specific providers, many participants wanted to ensure their freedom to choose providers in the future, which they perceived would have been restricted if they joined an MMP. Some participants actually experienced this restriction when they decided to accept the MMP and found that they could not see their doctors, and thus in response opted out before the January 1st effective enrollment date.

RESEARCH LIMITATIONS

The research team made every effort to provide reliable and valid results. However, there are limitations to qualitative research in general, and this study design in particular, that should be considered when reviewing the research results. We describe those limitations below.

Because the study was conducted with a limited number of participants, the team cannot know whether these results are representative of all individuals who have opted out of Cal MediConnect. Another limitation lay in the retrospective nature of the research. Because the interviewers asked participants to recall experiences and decisions made after a span of several months, some had difficulty remembering exact dates of plan communications and decisions.



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