THOMSON REUTERS

SUMMARY OF FOCUS GROUPS CONDUCTED

WITH MEDICARE-MEDICAID BENEFICIARIES IN CALIFORNIA

Oakland and Riverside

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Purpose of Focus Groups

The federal Medicare-Medicaid Coordination Office (MMCO) within the Centers for Medicare and Medicaid Services (CMS) sponsored a series of focus groups around the country in 2011 to learn more about how Medicare-Medicaid enrollees—persons who are enrolled in both the Medicare and Medicaid programs—experience the health care system. The MMCO has also awarded design contracts to California and 14 other states to plan/develop integrated care models for Medicare-Medicaid enrollees at the state level.

In August 2011, the MMCO conducted focus groups in California in partnership with the California Department of Health Care Services and two health plans, Alameda Alliance for Health and Inland Empire Health Plan. The California focus groups contribute both to MMCO's efforts to improve care nationally and California's efforts to reform health care delivery within the State. The objectives of the California focus groups were to:

- Learn about how Medicare-Medicaid enrollees perceive their Medi-Cal and Medicare coverage. Do they understand the difference? Do they think of them as separate, or as a package?
- Gain insight as to how Medicare-Medicaid enrollees make enrollment decisions, including, where available, the decision to enroll in integrated care (same plan for both Medicare and Medi-Cal).
- Identify coordination issues experienced by Medicare-Medicaid enrollees, and probe whether coordination is better, worse or the same for enrollees who are in integrated care v. those who are not.

Planning and Conducting the Focus Groups

Thomson Reuters and its partner, The Zacharias Group, conducted the focus groups under contract to the Medicare-Medicaid Coordination Office. The California Department of Health Care Services identified 2 health plans that offer both Medi-Cal and Medicare Advantage products, have significant enrollment among Medicare-Medicaid enrollees and were willing to draw random samples from their membership. Based on the objectives above, profiles were developed for each group to ensure that people with a variety of needs and experiences were invited. We then worked with the health plans to invite 350 persons per group who were randomly drawn from subsets of plan members who met the profile characteristics. Four groups were held between August 23 and 25, 2011. Table 1 provides the location, profile and number of participants who attended each group.

Table 1. Description of California Focus Groups

Group Profile	Date & Location	# Attending
Service Area: Alameda County **Service Delivery**: Integrated Product (Medicare and Medi-Cal from same plan) **Beneficiaries**: Medicare-Medicaid enrollee; 65 years or older.	Oakland August 23, 2011 10:30 a.m. Quantum Market Research	8
Service Area: Alameda County **Service Delivery**: Medi-Cal Managed Care; Medicare any option (integrated with Medi-Cal plan, received through plan or FFS) **Beneficiaries**: Medicare-Medicaid enrollee; 65 years or older; Chinese speaking.	Oakland August 23, 2011 1:30 p.m. Quantum Market Research	9
Service Area: Riverside and San Bernardino Counties **Service Delivery**: Medi-Cal Managed Care; Medicare elsewhere (received through plan or FFS) **Beneficiaries**: Medicare-Medicaid enrollee; 18-64 years of age; lives within 20 miles of research facility.	Riverside August 25, 2011 10:30 p.m. Athena Research Group	9
Service Area: Riverside and San Bernardino Counties **Service Delivery**: Integrated Product (Medicare and Medi-Cal from same plan) **Beneficiaries**: Medicare-Medicaid enrollee; 18-64 years of age; lives within 15 miles of research facility.	Riverside August 25, 2011 1:30 p.m. Athena Research Group	10
Total All Groups:		36

Transportation was provided for those who had requested assistance. The groups included participants who used wheel chairs or walkers for mobility, and a deaf person. The groups were moderated by Lee Zacharias and lasted 90-120 minutes. A translator was used for the Chinese language group and sign language interpreters for the group with a deaf participant. (For more details on how participants were recruited, see Appendix A.)

The moderator used a discussion guide to ensure that key topics were addressed, but also allowed and encouraged spontaneous discussion. We reviewed transcripts from the focus groups and summarized participants' responses by objective. Observations that came up

frequently but were not directly related to the 3 objectives are summarized as "Other Observations."

Findings by Objective

Objective 1: Learn about how Medicare-Medicaid enrollees perceive their MediCal and Medicare coverage. Do they understand the difference? Do they think of them as separate, or as a package?

- Overall, members understood that Medicare and Medi-Cal were separate programs, but most were not familiar with the differences. A few identified Medicare as federal and Medi-Cal as state. A few understood that Medicare is the first payer and covers 80% of hospital and doctor bills, and Medi-Cal supplements the coverage.

  "Medi-Cal pays what's left over."

  "I'm not sure which one covers what. I just give them my cards and say, "here!"

- Participants of the "integrated" groups (those receiving both Medicare and Medi-Cal through the same plan) viewed the two programs as a single package being delivered by the health plan. Members of the integrated groups were very happy with the comprehensive nature of their coverage.

Objective 2: Gain insight as to how Medicare-Medicaid enrollees make enrollment decisions, including, where available, the decision to enroll in integrated care (same plan for both Medicare and Medi-Cal).

- Some participants reported having made an enrollment decision in response to a provider or case worker recommendation.

  "My doctor recommended it. He said it was a good plan."

  "My Medi-Cal social worker suggested it."

  "I'd like to be on Dual Choice, but my psychiatrist won't take it, so I have to stay on straight Medicare."

- In Riverside (which consisted of persons under 65), some participants reported that their children had been enrolled with the plan, they were familiar with it, and wanted the same plan for themselves when they became dually eligible.

- Several participants in both locations reported that they chose integrated care (Medicare and Medi-Cal through the same plan) as a result of direct communication with a health plan. Some had heard a presentation at a senior center, health fair, Chinese festival or other venue, and had requested one-on-one follow-up. Others received a call or letter from their existing Medi-Cal plan, letting them know that they could add Medicare to their existing coverage with the plan.

  "I heard a presentation at our senior housing, and I wanted to know more, so a lady came to my apartment. She made it very easy for me."

- Several reported that they were attracted to integrated plans because they offered dental services. A few people mentioned eye glasses or transportation as benefits of integrated care.

  "They cover eyes, teeth, everything!"

- Others noted that the elimination of cost sharing was very important.

  "Medicare Advantage was OK at first, but then the monthly payment started creeping up. When I started, it was $30 a month, but then it was going to be $300, so that's when I switched to the Comprehensive."

- Participants enrolled in integrated plans reported having no problems or concerns with paperwork.

  "I would have been lost" [if he had been required to do his own paperwork].

- Some expressed a concern with making any switch, due to fear of losing benefits and not being aware of the loss.

  *"They'll tell you what you **will** get, but not what you **won't** get."*

- Some participants could not recall or explain how they had chosen a health plan. No one reported having received choice counseling from an enrollment broker.

- No one was familiar with the term "fee-for-service." They did not identify this as an option. A few people referred to "straight" Medicare when referring to FFS.

Objective 3: Identify coordination issues experienced by Medicare-Medicaid enrollees, and probe whether coordination is better, worse or the same for enrollees who are in integrated care v. those who are not.

- Participants from integrated plans reported a more seamless experience than those in separate plans. When those in integrated plans had problems (e.g., trouble with authorization for a service), they reported that a single call to the plan usually took care of the problem.

- Participants in integrated plans reported that their primary care practitioners (PCPs) and specialists were in communication with one another.

- In contrast, those who were in two separate plans for Medicare and Medi-Cal reporting getting "the runaround," in which they call one plan and are told to call the other plan.

  > *"I get a lot of back-and-forth between Medi-Cal and Medicare. It would be nice if someone could help me with that."*

- Participants in both integrated and Medi-Cal-only plans reported that they liked getting calls from their plans. They noted that getting regular calls made them feel like someone was watching out for them. They appreciated getting calls even if they had no issues or problems to report. (Not everyone had received calls, and it was unclear if those who were receiving calls had been targeted because of their service use or conditions.)

  > *"They call me to see if I have everything I need. Sometimes they call to see if I'm taking my medication."*

- Coordination of benefits appeared to be much more important to participants than clinical coordination of care.

  > *"Everything is covered. I just give them one card and I don't have to worry about co-pays, or which program pays what."*

  > "*My plan doesn't help me with Medicare problems. They tell me I have to call Social Security. There should be some functionality—I have both Medi-Cal and Medicare—they should help me with that."*

- The PCP's role in coordinating care (e.g., making referrals to specialists) is viewed by some as very helpful. Others view it as a restriction that is not necessarily beneficial to them.

  "He knows all the best specialists and can get me in to see them."

  "I can't just see a specialist. I have to get a referral from my regular doctor first."

- In Oakland, several participants in the integrated care group reported relying on various parts of Lifelong[1] for the things they needed, including primary care, dental, social work and legal services. When asked where they went if they had a problem, many mentioned that Lifelong can address most of their needs. When asked if they called the health plan for help with problems, participants responded that they would call the plan if they had questions about how the plan works or what it covers, or if they were having problems with service authorization. (Lifelong was not mentioned in the Chinese-speaking group, which had a mix of participants in integrated care or only Medi-Cal managed care.)

- Regarding admissions, participants reported a range of coordination experiences across the groups. Some had been referred to the hospital by their PCPs. Others had gone through the emergency room, without their PCPs' knowledge, but reported that their PCPs were notified soon after their admission. Others reported that their PCPs did not know of their admission until they notified them personally. Some reported that their medication was switched in the hospital, and their PCP was not aware of the change.

Other Findings

Primary Care Practitioners (PCPs)

- Everyone reporting having a PCP. About half the participants had long-term relationships with their PCPs (5 years or more).

- When asked what they want in a PCP, engagement emerged as a very important issue.

[1] Lifelong Medical Care is a nonprofit safety net provider of medical, dental, and social services, located in Alameda County.

"I want someone who knows me. Someone who looks at my chart, and actually asks me a question from my chart."

"All my doctor cares about is my blood sugar, which I don't care about—I care about my MS and they put it on the back burner."

"I like my doctor to shake my hand and give me eye contact."

"Someone who pays attention and asks lots of questions."

"Someone who listens and takes me seriously. Just because I'm a patient doesn't mean I'm an idiot."

"A doctor who trusts you as much as you trust him."

"Bedside manner."

- Participants in the Chinese-speaking group identified having a Chinese doctor who speaks Chinese as very important. (A few reported disappointment in having selected young Chinese doctors, and learning upon meeting them that they do not speak Chinese.)

- Other PCP preferences included: age (at least 40 years old); education; competence; and availability on weekends.

Prescription Drugs

- Participants in all groups reported good access to prescription drugs. For most, the co-pays (ranging from $0 to $3.30) were not a major barrier. Several reported that their pharmacists were very helpful in solving issues, such as expired prescriptions, drug interactions and formulary issues. One person reported that the pharmacist had come to his home.

Use of Emergency Services

- Several participants who had used the emergency room in the past year reported having called their PCPs first, and being advised to go to the emergency room. One person

reported that his PCP advised him to always call 911 and go by ambulance, rather than going on his own, because it reduces the wait time when you arrive.

Traditional Treatment

- Several Chinese-speaking participants reported using traditional herbalists, but did not see this as related to their plans, since it is not covered by the plans. They said they do not report seeing herbalists to their PCPs.

Receiving Information

- Most participants reporting that mail is their preferred method for receiving information. One person suggested using larger font on written materials, and this was seconded by several others.

- Several participants noted that the material needs to be simple, and focus on what they need to know. Benefits were cited as the most important information, with an emphasis not only on what is covered, but also what is not covered.

- Some of the Chinese speaking participants reported that they now received information in Chinese, but they had to specifically request it. One person suggested that this preference should be specifically probed at enrollment, because many people do not know that Chinese language materials are available.

Suggested Improvements

When asked what they would change about their health care, the following suggestions were made.

- Better coverage of dental and eye care.

- Less paper coming to the house.

  "Stop sending bills that say, "this is not a bill."

- Quicker approval time for referrals to specialists.

- Make materials easier to understand.

- Make redetermination for Medi-Cal less confusing. Have Medi-Cal call you back within 24 hours, which is promised on a recorded message but not delivered.

Appendix A. Focus Group Recruiting Methodology

Thomson Reuters and The Zacharias Group (TZG) staff worked with representatives from two partnering health plans, Alameda Alliance for Health and Inland Empire Health Plan, to develop and carry out the following recruitment plan:

- Based on the objectives for the focus groups, a profile for each group was developed that included service area, service delivery system (e.g., managed care or fee-for-service) and beneficiary characteristics. (The profile of each group is included in Table 1 of the report.)

- For each group, the applicable health plan drew a random sample from their member files of 350 persons who met the profile for that group. (For one profile, the entire group was slightly less than 350, and everyone fitting the profile was invited.)

- 3 weeks prior to the focus group dates, the health plan mailed written invitations to the randomly selected persons. The letters instructed interested persons to call TZG at a toll-free number if they wanted to volunteer for a group. As an incentive for this voluntary activity, the letter offered a $50 gift card to those selected. The letter also offered assistance with transportation.

- Calls were received by the focus group moderator who asked screening questions to ensure that the caller met the group criteria and held a bona fide invitation. Details were provided including an explanation that the group would be audio recorded, and would be observed by members of the research team and representatives from the state and federal governments. Callers who met the screening criteria and who stated they wanted to participate were asked for their verbal consent at that time and were told that a written consent would be completed at the group itself. Interested persons were also asked to provide contact information for follow-up confirmation.

- One week prior to the focus group dates, letters were sent to participants confirming date, time, and location and transportation source if applicable. Participants were encouraged to contact TZG if they had any questions or concerns and/or if they felt they would be unable to participate.

- On the day before the focus groups, focus group participants were contacted by phone to remind them of the groups and confirm any transportation arrangements required.