AgingToday

the bimonthly newspaper of the American Society on Aging

ISSN: 1067-8379 Page 1 SEPTEMBER–OCTOBER 2018

www.asaging.org volume xxxix number 5

Dual beneficiaries gauge the strengths (and weaknesses) of Cal MediConnect

By **Carrie Graham** and **Brooke Hollister**

Editor's note: The SCAN Foundation, The John A. Hartford Foundation, the Administration for Community Living, the Gary and Mary West Foundation, the Marin Community Foundation and the Colorado Health Foundation have united to fund a three-year grant to develop and establish the Aging and Disability Business Institute (goo.gl/nz7ykU)*, housed within n4a. Under the grant, ASA and n4a are collaborating on a series of articles* and case studies *in* **Aging Today** *that will help to prepare, educate and support community-based organizations and healthcare payers to provide quality care and services.*

Aging and Disability BUSINESS INSTITUTE
Connecting Communities and Health Care

The cohort of people who are dually eligible for both Medicare and Medicaid includes individuals with the most complex care needs, with high rates of chronic illness, disability and need for long-term services and supports (LTSS). These individuals experience additional barriers such as a lack of affordable housing and high costs of living (for duals living in poverty), and the potential for care duplication under these two programs, which often have competing incentives.

The 2010 Affordable Care Act created the Medicare-Medicaid Coordination Office (*tinyurl.com/bbs86xr*), which was tasked to partner with states to test "federal dual alignment demonstrations" (*tinyurl.com/ya5r5fz3*)—new, innovative models to better integrate care for duals. California, one of 13 participating states, designed a model that built upon its already well-developed infrastructure of capitated Medicaid managed care health plans, many of which had long been providing Medi-Cal (California's term for Medicaid). These health plans created new products, called Cal MediConnect (CMC; *calduals.org*), through which they provided both Medicare and Medi-Cal benefits, including managed LTSS.

Beginning in 2014, all eligible duals (including older adults and adults with disabilities) in seven counties were enrolled into CMC plans with the choice to opt out. By 2017 and the end of the demonstration, 116,000 duals were enrolled and received all of their Medicare and Medi-Cal benefits through

one plan, with one card. CMC plan enrollees were eligible for new benefits such as non-emergency transportation and care coordination services.

Researchers at the University of California conducted an evaluation of Cal MediConnect (*tinyurl.com/ybe8m5cb*), which included focus groups with dually eligible beneficiaries (CMC enrollees and opt-outs); surveys with beneficiaries [*tinyurl.com/y8ma8g2h*]; CMC, opt-outs and those in non-demonstration counties); and key informant interviews with policy makers, health plans, providers and advocates (*tinyurl.com/y9bp6q8u*). This article outlines the evaluation's key findings, program strengths and areas for improvement—data that are based on the beneficiaries' reported experiences.

Enrollee Satisfaction High, but Problems Remain

CMC enrollees' overall satisfaction was high and increased with time in the program: 94 percent said they were very or somewhat satisfied with care and 87 percent rated the quality of care as excellent or good. While those in comparison groups reported similarly high satisfaction ratings, there was no similar improvement over time.

A possibly more sensitive measure of access to care showed that one in five CMC beneficiaries reported they experienced delays or disruptions in care, and a year later, that disruption rate did not improve. While rates of disruptions were similar for the comparison groups, the availability of care coordination in CMC should have decreased disruptions for enrollees. California is addressing this issue, establishing a new Care Coordination workgroup to develop strategies for improved efficacy.

Including LTSS benefits in CMC was controversial, especially for disability advocates, who were concerned that the focus on cost containment could drive services reduction. An added complication was that In-Home Supportive Services (IHSS; California's consumer-directed personal care program) was only partially integrated, with CMC care coordinators having no authority to authorize services or increase hours; however, the plans were funded to allow plan care coordinators to collaborate closely in care planning with the IHSS social workers, who had the authority to authorize more hours.

Ultimately, this incentive to collaborate might have driven an increase in personal care hours for CMC enrollees. But unfortunately, funding has ceased for this collaboration between CMC plans and IHSS. Given that almost 40 percent of dual beneficiaries with LTSS needs report unmet needs for personal or routine care, more effort must be made to meet those needs. In response, California has required plans to assess CMC enrollees, during health risk assessments, for unmet LTSS needs (for the Cal MediConnect HRA workgroup's summary of recommendations, see *tinyurl.com/yb68pru8*).

High Opt-Out Rates: What Do They Mean?

About half of duals eligible for CMC decided to opt out of the program soon after enrollment; because of the fiscal implications, this could be construed as program failure. The people who opted out tended to have more disability than those who remained in the program. Focus groups and surveys involving opt-out beneficiaries revealed that they most often did so for three reasons: First, many opted out because their Medicare providers were not part of the CMC provider networks and these beneficiaries wanted to retain their physicians. This is understandable for those with complex conditions, who require the expertise of multiple specialists.

Second, many beneficiaries opted out because they did not fully comprehend the program. Most opt-outs surveyed reported that the notification letters informing them that they were to be passively enrolled in a managed care plan did not provide enough information for them to assess how the change would impact their care. Concern that they would lose benefits, especially for those with more disability, drove many to opt out. The notification letters also did not inform beneficiaries about some of the program's perks, such as care coordination services or transportation.

One CMC health plan representative said, "Beneficiaries were sent multiple letters with no information about the program. They were just told, 'You will be enrolled in this managed care plan and you only have 90 days to opt out.' Then they got another letter, 'Now you only have 30 days to opt out.' They were given no information about why the plan might be a good thing, but lots of instructions on how to opt out. So you can see that they would ... think, 'I better hurry up and opt out!' "

The fact that few beneficiaries disenrolled after the initial transition period should be taken into consideration when interpreting the high initial opt-out rate. For example, among the randomly sampled group of 488 CMC enrollees who were part of our first survey in 2016, less than half a percent disenrolled from CMC in the next year; and, among those who originally opted out, a larger number, 4 percent, decided to re-enroll in a CMC plan.

Lessons Learned and a Look to the Future

Given the large initial proportion of enrollees opting out, and, alternatively, the high satisfaction of those who remained in the program, there are a few lessons learned. First, California needs to do a better job of initially communicating the program's potential benefits and impacts on beneficiaries' care. Thus, California has developed a new, more explanative, consumer-friendly toolkit (*tinyurl.com/ybknrck2*).

Second, managed care plans must do a better job of engaging Medicare providers and inducing them to join their provider networks via a combination of competitive payment rates, additional services to support their work and more information about the additional benefits their patients may receive as part of the program.

Lessons learned from the CMC demonstration were used to refine new Medicaid waiver programs in California, such as the Whole Person Care Pilot (*tinyurl.com/ya7b2m3s*) and the Health Homes Program (*tinyurl.com/y7kzqb5s*).

While the demonstration is officially over, Cal MediConnect plans remain in place, at least through 2019. The state has made some program refinements, including improving consumer information, increasing access to non-emergency transportation, mandating more comprehensive needs assessments and creating more limited enrollment periods to reduce program turnover.

Though the future of CMC plans is unknown, most stakeholders agree that the trend toward more integrated care for dually eligible individuals is inevitable and, if implemented correctly, can potentially improve access to more streamlined care. ■

Carrie Graham, Ph.D., M.G.S., is director of Health Policy at UC Berkeley Health Research for Action and associate adjunct professor at the UCSF Institute for Health & Aging in San Francisco. Brooke Hollister, Ph.D., is an assistant professor at the Institute for Health & Aging.