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Beneficiaries Respond To California's Program To Integrate Medicare, Medicaid, And Long-Term Services

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ABSTRACT In 2014 California implemented a demonstration project called Cal MediConnect, which used managed care organizations to integrate Medicare and Medicaid, including long-term services and supports for beneficiaries dually eligible for Medicare and Medicaid. Postenrollment telephone surveys assessed how enrollees adjusted to Cal MediConnect over time. Results showed increased satisfaction with benefits, improved ratings of quality of care, fewer acute care visits, and increased personal care assistance hours over time. Enrollees also had somewhat better prescription medication access and lower unmet needs for personal care, compared to the comparison group. The lack of improvement in care coordination raises concerns about the implementation of the care coordination benefit, a key feature of the program. The Bipartisan Budget Act of 2018 contains provisions that permanently certify the use of managed care (such as Dual Eligible Special Needs Plans) to integrate Medicare and Medicaid, which makes the lessons learned from California's dual demonstration especially relevant for informing other integrated programs for seniors and people with disabilities.

Approximately 1.2 million adult Californians received health care and long-term services and supports in 2013 through a combination of Medicare and Medi-Cal (California Medicaid).¹ These “dual eligibles” typically have very low incomes, multiple complex chronic care needs, and multiple medical providers and account for a disproportionate share of spending in both programs.²⁻⁴ Nationwide, because of the aging of the population, the number of dually eligible beneficiaries rose by approximately 36 percent between 2006 and 2016⁵ and is expected to continue rising over the next decade. While beneficiaries in both Medicaid and Medicare have access to a greater range of services, silos of care and misaligned incentives across the two programs often result in inefficiencies, including duplication of care, poor coordination of care, and higher rates of avoidable hospitaliza-

tions,⁶⁻¹² which can increase the cost of health care.

In an effort to better integrate and coordinate the services provided by the two programs, California became one of thirteen states to implement a federal dual alignment demonstration in 2014.¹³ California's program, known as Cal MediConnect (CMC), was the largest, enrolling approximately 120,000 dually eligible seniors and adults with disabilities in seven counties by 2017.^{14,15} The structures of these demonstrations varied across states. California designed its dual demonstration using a capitated managed care model, building on existing Medi-Cal managed care organizations that developed new products called CMC plans.¹⁶ In addition to providing all traditional Medicare and Medicaid services, CMC plans provided nonemergency transportation, care coordination services, and other benefits.^{17,18} Care coordination require-

ments were loosely structured, allowing flexibility among plans in how they selected who would receive care coordination, with some plans developing an internal care coordination workforce and others delegating care coordination to outside entities.^{19–22}

Specialty behavioral health care was “carved out” of the demonstration and provided instead by county behavioral health care providers, while mild-to-moderate behavioral health services were provided by CMC providers (primary care providers or in-network specialists). CMC care coordinators were tasked with coordinating behavioral health services across sites.²³

Medicare and Medi-Cal long-term services and supports—including skilled nursing care; rehabilitation; community-based adult services (formerly known as adult day health care); and services provided by the In-Home Supportive Services (IHSS) Program, Medi-Cal’s consumer-directed personal care services program—were integrated into the CMC plans to varying degrees. For example, county social service agencies retained responsibility for determining eligibility for in-home supportive services, while CMC plans could recommend reassessment and received funding for coordinating these services.^{17,24}

While all dual eligibles in the seven demonstration counties were passively enrolled in CMC, they could “opt out.” Approximately 50 percent of those eligible did opt out soon after their passive enrollment.^{25–27} The primary reasons beneficiaries gave for opting out included wanting to continue seeing a provider who was not part of the CMC provider network, concerns that CMC would not cover specific services or benefits they needed, being content and satisfied with their fee-for-service Medicare, and finding the CMC program complicated and hard to understand (which rendered opting out a safer choice).²⁷ Those who opted out were still required to join a managed care plan to receive their Medi-Cal benefits and long-term services and supports, but they were able to keep their original Medicare benefits.

While past research has shown that seniors and people with disabilities can experience some disruptions in care immediately following a transition to a managed care delivery system, research also suggests that many disruptions are ameliorated over time.²⁸ In this postenrollment evaluation examining the experiences of CMC enrollees, we expected that in many domains, more time in CMC might result in more positive experiences as the program matured, with beneficiaries becoming more experienced at navigating CMC and the state and health plans engaging in course corrections and program im-

provements. This study addressed two main research questions: What were the experiences of beneficiaries who were enrolled in CMC compared to those in nondemonstration counties at the most mature point in time? And how did CMC enrollees’ experiences with care change over time after initial enrollment?

Study Data And Methods

As noted previously, seven counties took part in the Cal MediConnect demonstration. For the purposes of our evaluation, we selected nine counties that did not participate in the demonstration as a comparison group. These nine counties were selected because they had long-term Medi-Cal managed care infrastructures similar to those in the demonstration counties. We did not include rural counties where Medi-Cal managed care was recently introduced in 2014.

We conducted a survey of dually eligible beneficiaries enrolled in CMC and of the comparison sample of dual eligibles in nine nondemonstration counties, by telephone at two points in time. The initial survey was administered in January 2016, at which point CMC enrollees had been enrolled in the program for six to twenty-two months. A follow-up survey of the same beneficiaries was conducted in January 2017.

STUDY SAMPLE We obtained two lists from the California Department of Health Care Services pulled in July 2015, approximately four months after the completion of the first wave of CMC passive enrollment. One list included dually eligible beneficiaries residing in six demonstration counties who had been passively enrolled in CMC. About half of the people on that list were enrolled in CMC, and half had opted out of the program. The list included only those who were fully eligible for Medicare Parts A and B, had been enrolled in CMC (or opted out) in the period April 2014–July 2015, were age twenty-one or older, and had been enrolled in Medi-Cal for at least six months before transitioning to CMC. The list included only beneficiaries whose primary language was noted as English, Spanish, American Sign Language, or another sign language. The second list included all dually eligible beneficiaries in the nondemonstration counties who met the same criteria as the CMC counties. For additional information on data cleaning and the winnowing down of the sample, see online appendix exhibit 6.²⁹

We examined three groups of randomly selected beneficiaries: CMC enrollees, duals in CMC counties who had opted out of the demonstration, and duals in nondemonstration counties. To provide the cleanest comparison, this article

compares only the groups one and three, excluding duals who opted out. For more details, see the “Limitations” section below.

DATA COLLECTION A total of 744 CMC members completed the initial survey, for a 65 percent response rate.³⁰ One year later, respondents to that survey who had agreed to be contacted again were asked to participate in the follow-up survey. A total of 488 CMC enrollees completed the second survey and were included in the analysis, resulting in a retention rate of 66 percent. Seventy-eight beneficiaries who were in the opt-out group in the initial survey but had enrolled in CMC by the time of the follow-up survey were excluded from this analysis.

A comparison group of 736 beneficiaries randomly sampled from nondemonstration counties completed the initial survey, for a response rate of 70 percent,³⁰ and 474 of those also completed the follow-up survey (a retention rate of 64 percent).

Surveys were conducted in English and Spanish. Beneficiaries unable to complete the survey for themselves could elect a proxy to complete the survey in their stead. These proxies had to be people who made health care decisions for the beneficiary. Approximately 3–5 percent of the follow-up surveys were completed by proxies. Participants (but not proxies) were mailed a \$10 gift card as an incentive for each survey.

MEASUREMENT We used input from a project advisory group and early beneficiary focus groups to inform the development of a survey instrument that included five key domains: general satisfaction with benefits, access to care, use of health care services, use of long-term services and supports and unmet needs, and care coordination. Survey questions were pilot-tested in English and Spanish with a small group of beneficiaries, and the instrument was revised to improve readability and understandability. The survey also included a set of questions about sociodemographic characteristics, health, and disability status.

ANALYSIS Descriptive statistics were calculated for the sociodemographic variables and the health indicators for the CMC sample and the comparison group.

To assess whether the experiences of CMC participants differed from those of the comparison group, descriptive statistics were calculated for various measures of beneficiary experience and outcomes reported in the follow-up survey (see appendix exhibit 2).²⁹ Next, regression analyses were used to examine differences between the CMC and comparison groups at the follow-up survey. Regression models controlled for the following sociodemographic variables and health indicators: age group, race/ethnicity, survey lan-

guage, education, self-reported health status, disability status, and household composition. Logistic regression was used for dichotomous dependent variables; ordered logistic regression was used for ordinal dependent variables related to satisfaction, frequency, and quality of care; negative binomial regression was used for utilization count data; and median regression was used for the number of hours of in-home supportive services received.

To address the research question about the changing experiences of beneficiaries after enrollment, paired within-group analyses were conducted for the 488 CMC beneficiaries (exhibit 3) and the 474 members of the comparison group (appendix exhibit 3)²⁹ who responded to each question in both surveys. Wilcoxon signed-rank tests assessed whether there was a significant difference between the percentage of beneficiaries whose ratings increased/improved and the percentage of beneficiaries whose ratings decreased/got worse between the two surveys.

This project was approved by the human subjects committees for the State of California (Institutional Review Board No. 15-01-1853) and the University of California San Francisco (IRB No. 15-16186).

LIMITATIONS Our study had several limitations. First, while a sample of beneficiaries who were eligible for CMC but had opted out were surveyed for the evaluation, they were excluded from this analysis to provide a cleaner comparison between those who had participated in the program and those in counties where it was not implemented. Most beneficiaries opted out soon after their passive enrollment and had little or no experience with CMC before opting out. A tiny fraction of CMC enrollees in our study (<0.5 percent) opted out after they were assigned to our CMC group. However, exclusion of the opt-out group introduced some bias. Those who opted out differed from those who remained in CMC in terms of sex, race/ethnicity, and disability status. Furthermore, it is likely that those who opted out would have had more negative experiences with the program if they had remained in it, especially if they had been forced to change providers. Thus, the results of this study are generalizable only to those beneficiaries who did not opt out of the program. Preliminary results for the opt-out group in the initial survey were presented in a previous technical report.²⁷ Further details regarding sample characteristics and results from the opt-out group are available in appendix exhibits 4 and 5.²⁹

Second, because of how survey respondents were selected, the sample underrepresents beneficiaries living in nursing facilities and those

whose primary language was not English, Spanish, or sign language. Also, the study was limited to six of the seven demonstration counties, because one county was delayed in implementation.

Third, this study was limited to within-group comparisons of beneficiaries' changing experiences in the postenrollment period. The survey did not include a baseline before CMC enrollment, and the sampling methods did not enable us to detect small changes that we might see using a difference-in-differences approach. Instead, these analyses assessed experiences in the program in the follow-up survey, the most mature time period, as well as trend changes in the years after CMC enrollment.

Fourth, while response and retention rates were above 60 percent, it is possible that people who were less satisfied with CMC refused to participate in the initial survey or were lost to follow-up at the time of the second survey. This could have produced more positive results.

Fifth, the data were self-reported and represent the views of the dually eligible beneficiaries about their own care and experiences. Future research should examine Medicare and Medicaid encounter data that could verify the utilization data reported by beneficiaries.

Study Results

SAMPLE CHARACTERISTICS Exhibit 1 presents sociodemographic characteristics and health indicators for the Cal MediConnect and comparison-group samples. There were some significant differences between the CMC and comparison groups. CMC beneficiaries were less likely to be female (57 percent versus 64 percent) and more likely to be Latino (54 percent versus 37 percent). Because CMC counties had larger Latino populations than comparison counties, a higher proportion of the CMC group took the survey in Spanish (39 percent versus 22 percent). Fewer CMC respondents were high school graduates (57 percent versus 70 percent). Lower proportions of the CMC group had difficulty remembering, concentrating, or making decisions (29 percent versus 35 percent); walking or climbing stairs (57 percent versus 64 percent); and doing errands alone (36 percent versus 42 percent).

DIFFERENCES BETWEEN GROUPS IN THE FOLLOW-UP SURVEY Both the CMC and comparison groups rated their satisfaction with their health insurance benefits and the quality of their care fairly high, and there were no significant differences between the two groups (exhibit 2).

Regarding access to care, CMC beneficiaries reported a slightly greater likelihood of

experiencing delays or problems in getting care, but the significance was marginal. Members of the CMC group were also less likely to report having out-of-pocket spending for prescription medications. There were no significant differences between the two groups in measures of access to acute, primary, specialty, or mental health care or to durable medical equipment and supplies.

In terms of the use of care, the only significant difference between the two groups in the follow-up survey was in the area of durable medical equipment and supplies: CMC beneficiaries were more likely than those in the comparison group to report using medical equipment and supplies in the follow-up survey.

In the area of long-term services and supports, over a third (37 percent of the CMC group and 44 percent of the comparison group) of the respondents who needed them reported unmet need for routine help in the follow-up survey. Furthermore, 26 percent of users of long-term services and supports in the CMC group, and 43 percent in the comparison group, reported unmet need for personal care assistance, with those in the CMC group significantly more likely to get all the help they need ($p = 0.019$).

There were no significant differences between the two groups in the domain of care coordination.

TRENDS IN CAL MEDICONNECT BENEFICIARIES' EXPERIENCES WITH CARE AFTER ENROLLMENT

Significantly more CMC beneficiaries reported increased satisfaction than reported decreased satisfaction with health insurance benefits over time (24 percent versus 12 percent) (exhibit 3). The numbers for the comparison group were similar (25 percent versus 12 percent) (see appendix exhibit 3).²⁹

In terms of quality of care, significantly more CMC beneficiaries increased their rating over time (27 percent) than decreased their rating (18 percent). There was no similar change in the comparison group, where an equal amount (about 18 percent) increased and decreased their quality-of-care rating.

There were also some changes in the use of health care for the CMC group in the years after enrollment. In terms of acute care, significantly more CMC beneficiaries reported a decrease in hospital admissions between the surveys than reported an increase (18 percent versus 12 percent). Similarly, CMC beneficiaries were significantly more likely to report decreased emergency department (ED) visits than increased visits (26 percent versus 18 percent). There were no significant changes in hospitalizations or ED use for the comparison group. There was no significant change in the use of primary care or mental

EXHIBIT 1

Sociodemographic characteristics and health indicators for the Cal MediConnect (CMC) and comparison groups

	CMC group (n = 488)	Comparison group (n = 474)
AGE GROUP (YEARS)		
18-44	8.0%	7.6%
45-54	11.1	13.1
55-64	18.7	20.3
65-74	40.0	39.2
75 or more	22.3	19.8
SEX		
Female	56.6%	63.9%**
RACE/ETHNICITY		
Latino	54.4%	36.5%****
White	33.2	36.5
African American	15.0	17.1
American Indian, Alaska Native, Asian, or Pacific Islander	5.9	8.4
SURVEY LANGUAGE		
English	61.5%	77.9%
Spanish	38.5	22.2****
EDUCATION		
High school graduate	56.5%	69.7%****
HOUSEHOLD COMPOSITION		
Living alone	27.0%	35.0%
Living with other adults	61.7	55.3
Living in congregate setting	11.3	9.8**
SELF-REPORTED HEALTH STATUS		
Good or excellent	46.5%	43.0%
Fair	38.4	43.4
Poor	15.2	13.7
DISABILITY STATUS		
Deaf or difficulty hearing	19.0%	19.2%
Blind or difficulty seeing	20.9	20.2
Difficulty remembering, concentrating, making decisions	28.9	35.1**
Difficulty walking or climbing stairs	56.6	63.5**
Difficulty bathing or dressing	26.2	30.6
Difficulty doing errands alone	35.5	41.7**
NEEDED A SURVEY PROXY		
Yes	5.1%	3.0%

SOURCE Authors' analysis of responses to the beneficiary survey. **NOTES** Demographic variables (including age, sex, race/ethnicity, survey language, and education) were from the first survey (since they were not asked again during the second survey); the remaining variables are from the second survey. Statistical significance denotes a significant difference between the CMC group and the comparison group using chi-square tests. ***p* < 0.05 *****p* < 0.001

health care for either group. Nor was there a change in specialty care use for the CMC enrollees, while there was only a marginally significant increase for the comparison group (appendix exhibit 3).²⁹

There were some changes in the use of and need for durable medical equipment and supplies in both groups. First, there was a significant increase in reported use of equipment and supplies in the CMC group in the follow-up survey,

with 12 percent reporting no use in the first survey but reporting use in the second. This was significantly higher than the 8 percent who reported use in the first but not the second survey. There was no significant change in use among the comparison group. There was no corresponding reduction in unmet need for equipment and supplies among the CMC beneficiaries, yet unmet need increased significantly in the comparison group over the same period.

Regarding long-term services and supports, there were no significant changes in either group in enrollment in the IHSS Program between the surveys. However, 60 percent of the CMC beneficiaries who used the services reported an increase in hours of use between the surveys—significantly more than the 24 percent who reported a decrease. No significant change in hours of use was apparent in the comparison group. Nor did either group have significant changes in unmet need for long-term services and supports.

Finally, in the domain of care coordination, there was no significant change in unmet need in either group. However, 32 percent of the CMC group and 33 percent of the comparison group perceived that communication and data sharing between providers decreased over time.

Discussion

California was one of the first states to begin using managed care to deliver Medicaid in the 1970s. By the 1990s almost all of the general Medi-Cal beneficiaries in the most populous California counties were enrolled in Medi-Cal managed care organizations. In 2012 the state made a somewhat controversial decision to begin mandatory enrollment of seniors and people with disabilities into managed care plans,²⁸ and in 2013 Medi-Cal managed care was further expanded into rural counties.³¹ It was this already well-developed managed care network that was used to build the Cal MediConnect program for duals. CMC plans were challenged to develop new provider networks that included Medicare providers as well as networks of long-term care facilities, relationships with home and community-based providers of long-term services and supports, and new care coordination departments.

People who were enrolled in CMC and did not opt out of the program reported high satisfaction with their health insurance benefits and gave high ratings to their quality of care in the follow-up survey, and trend data show that satisfaction and quality ratings improved over time. These findings may indicate that misgivings about managed care or problems as a

EXHIBIT 2
Attitudes about and use of care by the Cal MediConnect (CMC) and comparison groups at T2 (follow-up), January 2017

Question (reference response)	CMC group ^a	Comparison group ^a
GENERAL SATISFACTION AND ACCESS		
Overall, are you currently satisfied or dissatisfied with your benefits? (Very satisfied)	73.3%	68.9%
How would you rate the overall quality of care you are currently receiving? (Excellent)	49.0%	51.4%
In last year, have you experienced delays or problem getting care, services, supplies you need? (Yes)	20.3%	18.6%**
ACUTE CARE USE AND ACCESS		
In last six months, how many different times did you stay in the hospital overnight or longer?	0.63	0.37
In last six months, how often were you able to go to the hospital you wanted to go to? (All the time) ^b	67.9%	70.6%
When leaving the hospital, did you feel comfortable going home/ready to go home? (Yes) ^b	88.6%	86.0%
After discharging from the hospital, were all your needs at home met, or did you have any unmet needs for assistance or services at home? (I had everything I needed at home) ^b	85.9%	86.7%
In last six months, how many times did you visit the emergency department for your own health?	0.58	0.84
PRIMARY AND SPECIALTY CARE USE AND ACCESS		
In last six months, how many times did you visit a primary care provider to get care for yourself?	3.3	3.2
In past six months, how many days did you usually have to wait for an appointment when you needed care right away? (Same day) ^c	49.9%	43.1%
In last six months, how many times did you visit any kind of specialist to get care for yourself?	2.5	2.9
In last six months, have you ever had a problem getting referral or approval to see specialist? (Yes)	8.9%	8.7%
In last six months, how often was it easy to get appointments with specialists? (Always) ^d	57.6%	52.1%
MEDICAL EQUIPMENT AND SUPPLIES USE AND UNMET NEED		
Do you use any medical equipment or supplies? (Yes)	55.5%	52.7%**
Do you need any medical equipment or supplies that you cannot get through health insurance? (Yes)	22.8%	25.2%
PRESCRIPTION MEDICATION USE AND ACCESS		
About how many different prescription medications are you currently taking?	6.3	6.6
In last six months, how often was it easy to get your prescription medications? (Always easy) ^e	79.7%	75.2%
In past six months, have you paid out of pocket for your prescription medication? (Yes) ^e	62.0%	73.3%***
MENTAL HEALTH CARE USE AND ACCESS		
In last six months, how many times did you visit mental health providers to get care for yourself?	0.79	1.00
Are there any mental health services you feel you need but you are not getting? (Yes)	8.7%	9.7%
In last six months, how often was it easy to the mental health services and appointments you needed? (Always easy) ^f	61.0%	50.0%
LONG-TERM SERVICES AND SUPPORTS USE AND ACCESS		
Do you usually get all the help you need with routine needs? (Needs more help or gets no help) ^g	37.0%	43.8%
Do you usually get all the help you need with personal care needs? (Needs more help or gets no help) ^h	25.9%	42.7%**
Are you currently using In-Home Supportive Services (IHSS)? (Yes)	54.7%	53.9%
Currently, how many IHSS hours are you getting per month? ⁱ	82.0	89.5
CARE COORDINATION USE AND ACCESS		
In last six months, did you have contact with ANY care coordinator? (Yes)	25.3%	24.0%
Are you getting all the care coordination services you need? (I get all the help I need)	68.2%	70.1%
In past six months, how often did doctors or other health care professionals share important information about your medical history or treatment with each other? (Always) ^d	41.8%	41.9%

SOURCE Authors' analysis of responses to the follow-up beneficiary survey. **NOTES** Regression models controlled for the following sociodemographic variables and health indicators: age group, race/ethnicity, survey language, education, self-reported health status, disability status, and household composition. T2 refers to the follow-up survey described in the text. Medical equipment refers to durable medical equipment. ^aPercent or mean. Sample sizes are in exhibit 1. ^bAsked of 108 members of the CMC group and 107 comparison-group members who used hospital care at T2. ^cAsked of 515 CMC members and 414 comparison-group members who used primary care at T2. ^dAsked of 375 CMC members and 325 comparison-group members who used specialty care in the six months prior to T2. ^eAsked of 530 CMC members and 442 comparison-group members who used prescription medication at T2. ^fAsked of 119 CMC members and 97 comparison-group members who used mental health care at T2. ^gAsked of 204 CMC members and 188 comparison-group members who needed help with activities of daily living or instrumental activities of daily living at T2. ^hAsked of 133 CMC members and 120 comparison-group members who needed help with personal care needs at T2. ⁱAsked of 117 CMC members and 104 comparison-group members who used IHSS at T2. Median instead of mean reported because median regression was conducted on this variable. ***p* < 0.05 ****p* < 0.01

result of the initial transition to CMC were resolved for some beneficiaries with more time in the program—as was suggested in earlier focus-group and key-informant interview findings^{32,33}—or that some benefits of integrated care became more apparent to beneficiaries over time.

A key part of the program was the integration of long-term services and supports, which involved the use of interdisciplinary care teams to facilitate closer coordination between CMC plans and various agencies that provided the services and supports—most notably, California's IHSS Program for personal care assistance.

EXHIBIT 3

Changes in attitudes about and use of care by the Cal MediConnect (CMC) group after enrollment, between January 2016 and January 2017

	Percent of respondents who reported:		
	Increased or improved	No change	Decreased or got worse
GENERAL SATISFACTION AND ACCESS			
Satisfaction with health insurance benefits	24.1	63.7	12.2****
Rating of overall quality of care	27.0	55.5	17.5***
ACUTE CARE USE AND ACCESS			
Overnight hospital admissions	12.1	70.5	17.5**
ED visits in the last 6 months	18.2	56.3	25.5**
PRIMARY AND SPECIALTY CARE USE AND ACCESS			
Primary care visits	30.4	32.7	36.9
Access to timely primary care appointments ^a	25.7	47.5	26.8
Specialty care visits in the last 6 months	26.9	41.8	31.3
Ease of getting specialty care appointments ^b	24.8	52.3	22.9
MEDICAL EQUIPMENT AND SUPPLIES USE AND UNMET NEED			
Using medical equipment or supplies	12.4	79.6	8.0**
Unmet need for medical equipment or supplies	10.2	79.1	10.8
PRESCRIPTION MEDICATION USE AND ACCESS			
Current prescriptions	34.5	31.6	33.9
Ease of getting prescription medication ^c	12.0	75.8	12.2
MENTAL HEALTH CARE USE AND ACCESS			
Used mental health services (yes/no)	3.7	92.0	4.3
Mental health care visits in the last 6 months	6.4	83.8	9.8
Unmet need for mental health services	4.3	90.5	5.2
LONG-TERM SERVICES AND SUPPORTS USE AND ACCESS			
Currently using IHSS Program	8.7	88.1	3.2
Hours of IHSS used per month ^d	60.0	16.4	23.6****
Unmet need for routine or personal care help ^e	18.7	67.5	13.8
CARE COORDINATION USE AND ACCESS			
Unmet need for care coordination ^f	10.8	72.5	16.7
Providers shared information about medical history with each other	16.1	51.6	32.3****

SOURCE Authors' analysis of CMC group responses to the initial and follow-up beneficiary surveys. **NOTES** T1 and T2 refer to the original (January 2016) and follow-up (2017) surveys described in the text. Statistical significance denotes difference between the percent whose score increased/improved and the percent whose score decreased/got worse between the first and second surveys using Wilcoxon signed rank tests. ED is emergency department. ^aAsked of 334 members of the CMC group and 304 comparison-group members who used primary care at both T1 and T2. ^bAsked of 254 CMC members and 198 comparison-group members who used specialty care at both T1 and T2. ^cAsked of 483 CMC members and 416 comparison-group members who used prescription medication at both T1 and T2. ^dAsked of 71 CMC members and 58 comparison-group members who used IHSS at both T1 and T2. ^eAsked of 154 CMC members and 148 comparison-group members who needed help with daily activities at both T1 and T2. Unmet needs for personal care and routine care are combined in this analysis. ^fAsked of 129 CMC members and 70 comparison-group members who used care coordination at both T1 and T2. ***p* < 0.05 ****p* < 0.01 *****p* < 0.001

Although rates of unmet need for personal assistance among users of long-term services and supports in both the CMC and comparison groups were remarkably high, CMC enrollees reported significantly lower unmet needs for personal care in the follow-up survey than the comparison group did. The significant increase in hours of use of in-home supportive services reported by CMC enrollees between the surveys suggests that the efforts of CMC care coordinators to collaborate more closely with the IHSS Program (including strategies such as colocating staff to more easily request reassessment for

hours of the services)¹⁷ appeared successful in increasing access to personal care among CMC beneficiaries. This is not surprising, considering that the CMC plans may have been motivated to advocate for increased personal care assistance hours if they felt that the additional hours could prevent more costly institutional care. Unfortunately, as of January 1, 2018, the provision of in-home supportive services was removed as a Medi-Cal managed care benefit, and the funding for collaboration between the CMC and the IHSS Program ceased. It remains to be seen whether the gains in collaboration between the plans and

the program will continue without this funding.

The provision of durable medical equipment and supplies is something that may require more attention from CMC plans. While CMC beneficiaries increased their use of the equipment and supplies over time, there was no corresponding decrease in unmet need, with more than one in five members of the CMC group still reporting unmet need after two or more years in the program. Considering that members of the comparison group increased their unmet need over the same time period, it is reasonable to conclude that CMC plans made some progress in providing the equipment and supplies for their members, but that more efforts need to be made to ensure that members are not going without critical assistive equipment and supplies.

Access to prescription medications is always a concern when transitioning to a new delivery system, especially with a population that requires an average of six prescription medications (see exhibit 2). Paying out of pocket for a prescription medication can be a sign that the switch to a new pharmacy provider or change in a managed care organization's formulary resulted in a disruption in medication access. Results of this study show that a majority of CMC beneficiaries reported having to pay out of pocket for prescription medications at some point, but this proportion was significantly lower than that in the comparison group. We can conclude that while prescription access is a common problem among all duals, CMC plans have made some progress in improving access, with more improvements still needed.

While there were no significant differences between the CMC group and the comparison group in hospital or ED use in the follow-up survey, there was a significant decrease in the frequency of both reported hospital admissions and ED visits between the surveys for the CMC group. Unnecessary hospitalization and ED use contribute to overall high costs of care for those with complex care needs.¹² The self-reported decrease in acute care use is a promising result for the assessment of cost of the CMC program and should be a focus of future analysis of encounter data.

Finally, since the new care coordination benefit was a key element of CMC, it was expected that the CMC group would have better results for care coordination than the comparison group did. However, no measures showed improvement for CMC beneficiaries. Focus groups with CMC beneficiaries early in the evaluation suggested that many people were not aware of the availability of care coordination.³² Thus, CMC plans need to do a better job of identifying and reaching out to members who may need care coordination and

making the availability of the benefit more widely known. Furthermore, the practice of delegating care coordination to outside entities should be examined more closely.³³ It should also be noted that the complications of coordinating care for carved-out services such as specialty behavioral health care may be difficult to overcome for CMC plans with nascent care coordination programs. The perceived decrease in provider communication over time should prompt CMC plans to review their data-sharing procedures and improve communication across network providers.

Federal rules prohibit states from mandating that Medicare beneficiaries enroll in managed care. Thus, dually eligible beneficiaries had the right to opt out of the Medicare portion of CMC. About half of those who were passively enrolled opted out because of concerns about switching providers, potential disruptions in care, and a lack of understanding of the program.^{25,27} California has made efforts to improve communication materials provided during the enrollment process to better describe the program to enrollees, including better descriptions of the new benefits offered. But to prevent high opt-out rates and maintain continuity of care in the future, CMC plans must do a better job of including Medicare providers in their networks.

Conclusion

Our evaluation of the Cal MediConnect integrated managed care model for dually eligible beneficiaries showed some promising results for those who did not opt out of the program. Those with misgivings about using integrated managed care for dually eligible seniors and people with disabilities should be encouraged to learn that beneficiaries' experiences with CMC were, in most cases, not worse than the experiences of people in the comparison group, in some areas improvement over time; and that our results showed promise in the areas of personal care assistance prescription medication access and potential reductions in acute care use. But the evaluation also revealed areas where CMC plans have more work to do to meet the needs of members, especially in the areas of care coordination and durable medical equipment. Results of this study can inform the use of managed care for duals or other people with complex care needs and may be especially relevant given that the Bipartisan Budget Act of 2018³⁴ contains provisions that permanently certify the use of managed care, such as Dual Eligible Special Needs Plans to integrate Medicare and Medicaid for dually eligible beneficiaries. ■

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