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Evaluation of Cal MediConnect
Key Findings from a Survey with Beneficiaries

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Introduction

The UCSF Community Living Policy Center and the UC Berkeley Health Research for Action Center have partnered to conduct an evaluation of Cal MediConnect, part of California's Coordinated Care Initiative (CCI). The CCI demonstration integrates Medicaid and Medicare services for dually eligible beneficiaries, a population with an often complex array of needs. Health plans in seven California counties created new "Cal MediConnect" products to coordinate all medical, behavioral health, long-term institutional, and home- and community-based services through a single organized delivery system. The evaluation uses both focus groups and a representative telephone survey to assess beneficiaries' experiences with care, including access, quality, and coordination. The telephone survey key findings, methodology, and data tables are reported below. For a summary of focus group results, click here. The evaluation also examines service delivery system response to the initiative in several sectors, including health plans, medical care providers, behavioral health, skilled nursing, and home- and community-based services. For results of health system response study, click here.

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Telephone Survey with Beneficiaries

As part of this three-year evaluation, researchers conducted a representative telephone survey with 2,139 beneficiaries who were dually eligible in early 2016. The purpose of the telephone survey was to examine beneficiaries' experiences with Cal MediConnect (CMC). We compared the experiences of CMC beneficiaries with those who opted out, as well as dual eligibles who reside in non-demonstration counties, to identify areas where experiences are significantly better or worse than those who did not participate. Just over a third of those who participated in the study (n=774, 36%) were enrolled in CMC. Just under a third (n=659, 31%) of the beneficiaries interviewed lived in CCI counties and had opted out of the program, meaning they kept their Medicare the same, but received Medi-Cal health benefits and managed long-term services and supports (MLTSS) from a health plan. Another third (n=736, 34%) were dually eligible beneficiaries from non-CCI counties who were not impacted by the demonstration. A second, follow up survey will be conducted in early 2017 with the same beneficiaries to assess how their experiences have changed over time. The key findings, insights, and recommendations from the telephone survey are summarized below. The California Department of Health Care Services (DHCS) has added comments to describe their actions in response to these and other early evaluation results. Please see Appendix 1 for a complete description of the survey methodology, and Appendix 2 for data tables.

#1 Most Cal MediConnect beneficiaries are satisfied with their insurance benefits.

Similar to those in non-demonstration counties or those who opted out, 90 percent of CMC beneficiaries were satisfied with their health insurance benefits, and 83 percent said their quality of care was generally good or excellent. Over a third (36%) of CMC beneficiaries said care was better in the new program, a figure significantly higher than those who opted out. For those who said care was better in CMC, their primary reasons were that it was quicker and easier to get information about benefits as well as appointments or services, and their quality of care was better. Analysis also shows that those who have been enrolled in CMC for more than 19 months were more likely to say that their quality of care is better than those who had been enrolled for less time (see Tables 1 to 5).

- ***Insight: Cal MediConnect is working well for beneficiaries who enroll, and results suggest that more months in the program may result in increased satisfaction and perceptions of program benefits.***

#2 Continuity of care after the transition is a key concern for beneficiaries. Most beneficiaries wanted to keep the same providers, hospitals, and medicines that they had before the demonstration. Of those who enrolled in CMC, over three-quarters (77%) were able to keep the same primary care provider after switching to CMC; a majority kept all (66%) or some (20%) of their specialists; and three-quarters (74%) were able to participate without changing medications. Of those who had been to the hospital, 91 percent said they were able to go to the facility they preferred some or all of the time. It's likely that many people who would have had to change providers decided to opt out of the program. Keeping the same providers and medicines was highly correlated with higher overall satisfaction with Cal MediConnect. Of those who changed providers, just over a quarter (27%) were aware of the continuity of care provisions, which would have allowed them to ask to continue seeing out-of-network providers for up to a year (see Tables 6 to 13).

- ***Recommendations: DHCS and CMC health plans should elevate messages about the option of using continuity of care provisions in outreach and education materials for beneficiaries.***
- ***Continuity of care provisions should include access to off formulary prescriptions and out of network hospitals and laboratories wherever possible.***

DHCS Comment: Many beneficiaries who have joined Cal MediConnect to date have reported long-term relationships with their Medicare physicians, which we know has led to some transition issues. Maintaining access to physicians is an important beneficiary protection in Cal MediConnect, and DHCS has worked to help reduce the continuity of care transition issues reported by beneficiaries. DHCS has updated the continuity of care policies several times to allow beneficiaries access to retroactive continuity of care, to make it easier for beneficiaries to continue seeing out-of-network specialists, and to keep their Medicare doctors for longer. In terms of outreach efforts, DHCS has worked closely with health plans and other community partners to expand awareness of continuity of care policies through provider bulletins, the Physician Toolkit and Beneficiary Toolkit. Moving forward, newly-eligible Cal MediConnect beneficiaries are also more likely to be new to Medicare, which will help reduce these transition issues as their existing physicians may be more likely to already be in their Cal MediConnect plan of choice.

#3 Access to care improved for about a quarter of beneficiaries in CMC, especially in the areas of prescription medication, durable medical equipment/supplies, vision, and dental benefits. Just over a quarter of CMC enrollees said that it was easier to get appointments with primary (28%) and specialty (26%) care doctors than it had been before they switched to the program, while less than 10% said that access got worse after transition. Similar to those who opted out, though, the majority of beneficiaries said that access had not changed since switching to CMC. Overall, ease of getting appointments with medical providers was not different between CMC and non-CMC groups. Yet there were more marked improvements in other areas. For example, 78 percent of beneficiaries in CMC said that it was "always" easy to get their prescription medication, significantly higher than those who opted out or were in non-CCI counties.

Furthermore, over a quarter said that it was easier to get durable medical equipment and supplies (DME) after the transition to CMC, which is significantly more improvement than reported by those who opted out (of whom only 12% said access to DME was improved). Similarly, more CMC beneficiaries said dental and vision benefits were better since the switch, and were more likely to report improvement in these areas than those who opted out. Finally, high rates of emergency department use are often seen as an indicator of poor access to primary care. In this study, over a third (34%) of CMC beneficiaries said that since switching, they used the emergency room less than they had before, a significant improvement compared with those who opted out (see Tables 14 to 23).

- ***Recommendation: While these results show that CMC may be improving access for more than one in four beneficiaries, assessment of encounter data from health plans should be conducted to identify areas where more could be done to improve access to care for more beneficiaries.***

#4 Notification of Cal MediConnect could be improved. Most (71%) beneficiaries in CCI counties reported receiving notification letters mailed by the state before the transition. Though 44 percent of beneficiaries in CCI counties said the letters were "very useful," beneficiaries who opted out were more likely to say the letters were "not useful" than those who enrolled (24% opt-outs versus 8% enrolled). This suggests that the perceived usefulness of the letter was likely an important driver of enrollment choices. While early notification letters mentioned the name of the program and let beneficiaries know they could opt out, beneficiaries reported the letters did not explain some key aspects of the program, such as how managed care works. Furthermore, many were unaware of new benefits— overall, less than half (44%) of dual beneficiaries in CCI counties were aware that the program would provide additional transportation benefits (though those in CMC were more likely to be aware than those who opted out [50% versus 33%]) (see Tables 24 to 26).

When asked how the letters could be improved, beneficiaries said they should describe the new benefits people will gain from the program, including the new transportation benefit, care coordination, vision and dental services—as well as describing any benefits that would be lost. Some said that the letter was unclear or vague, and needed to be written in a way that everyone could understand. Since a major reason for opting out was the belief that one would lose access to a provider, beneficiaries need resources and simple tools that will tell them whether their providers are in-network and how to request continuity of care provisions for out-of-network providers (see Table 27).

- ***Recommendation: As CMC plans to move into voluntary enrollment, providing clear and complete information about the additional benefits provided and the availability of continuity of care provisions will be especially important. While all parties want to avoid misleading marketing of any kind, beneficiaries have a right to detailed information about ways they may benefit from CMC plans as well as how to ensure continuity of their care.***

DHCS Comment: DHCS developed and revised the Cal MediConnect notices and materials with significant stakeholder and beneficiary input. However, as the evaluation efforts have shown, written materials are not always sufficient to effectively educate beneficiaries about the program and its potential benefits. DHCS, along with other stakeholders and partners, continues to work on the ground in CCI counties to reach and educate dual eligible beneficiaries about the program. These endeavors include targeted and culturally competent outreach in diverse communities. In addition, DHCS is working with the Cal MediConnect plans to encourage appropriate education and marketing efforts toward duals who may benefit from the program. An array of communication channels has been used to educate beneficiaries, including videos, telephone town halls, outbound phone calls, and in-person presentations and trainings.

DHCS is also working to ensure that new materials are available to better educate eligible beneficiaries and their providers about the promise of Cal MediConnect. DHCS has created both a Guidebook for new dual eligibles and a Cal MediConnect Beneficiary Toolkit to support beneficiaries, their key supports, and options counselors in choosing the best option to meet the beneficiaries' health needs. The Beneficiary Toolkit and new Guidebook have undergone stakeholder review and beneficiary user testing conducted by Health Research for Action at the UC Berkeley School of Public Health to improve the content to be more understandable for beneficiaries.

#5 Many disruptions experienced due to the change to Cal MediConnect were resolved through care coordination, but CMC care coordination is not always reaching those who may need it. Though one in five beneficiaries did report some disruptions in care when they transitioned to Cal MediConnect, a majority said that some (21%) or all (35%) disruptions were resolved. Those who were in fair or poor health, using medical equipment/supplies, or with more disability were more likely to report experiencing disruptions. Beneficiaries who did experience disruptions reported a variety of causes, including delays in getting medication or medical equipment/supplies and delays in appointments, especially caused by slow referral and authorization for specialists. Those with care coordinators were more likely to also report having disruptions resolved, compared to those with no care coordinator. Educational attainment and health literacy did not impact whether someone experienced a disruption after enrolling in CMC, suggesting that disruptions may not be blamed on beneficiaries' inability to navigate or understand their health benefits (see Tables 28 to 36).

- ***Insight: While some disruptions in care can almost always be expected in situations where people with complex care needs change delivery systems, these results highlight the importance of making sure that care coordination services are being targeted to beneficiaries who are most at risk for poor health outcomes or transition-related disruptions in care.***

#6 Beneficiaries had many reasons for opting out of Cal MediConnect that reach beyond "fear of change." All eligible beneficiaries in CCI counties were "passively enrolled" in a CMC plan, meaning that they were assigned to a plan. They were then sent notification letters indicating that they would be enrolled in their assigned plan unless they selected a different plan or actively opted out of the program. Opting out allowed them to keep their current Medicare option, but they still were required to go into a Medi-Cal managed care plan, including MLTSS. Around half of the eligible beneficiaries in demonstration counties did opt out, with females and those with functional impairment most likely to do so. Results from the survey also show that about 43 percent of those were unaware that they had opted out. Spanish speakers, older beneficiaries, and those with lower educational attainment were more likely to be unaware that they opted out. Those who were unaware they opted out were more likely to report difficulty getting specialty appointments and experienced more problems with physical access into doctor's offices. Though some beneficiaries may have simply forgotten, these results may indicate that some beneficiaries may have been opted out of the program without their intent or knowledge (see Tables 37 to 44).

Beneficiaries who were aware they opted out reported the most common reasons for doing so, including: 1) wanting to keep their current provider, 2) believing that CMC would not cover specific services or benefits they need, 3) being content and satisfied with their current Medicare and Medi-Cal benefits, and 4) finding Cal MediConnect difficult and complicated to understand, thereby rendering opting out a safer choice. A little over a quarter of beneficiaries who opted out said they were advised to do so, and for most of these the advice came from their medical provider or someone at the provider's office. Furthermore, the majority said that the process of opting out was "very" or "somewhat" easy. Only 14 percent of those who opted out said they would be interested in re-enrolling in Cal MediConnect (see Tables 45 to 49).

- ***Insight: High rates of satisfaction among both those who enrolled in CMC and those who opted out, along with the result that beneficiaries found opting out "easy," suggest that passive enrollment with the option to opt out was a successful strategy for CMC enrollment. With improvements in outreach and education strategies, continued passive enrollment for newly qualified dually eligible beneficiaries should be considered.***

DHCS Comment: The overarching goal of beneficiary outreach and education has been to provide high-quality information to beneficiaries, their families, and caregivers, so that they can make the best decision to meet their health care needs. DHCS and its partners have worked to revise and improve educational materials to help ensure beneficiaries have the information they need. For example, there was some confusion in the beginning months of passive enrollment regarding transitioning Medicare Part D prescription drug benefits from Part D plans to Cal MediConnect plans. This may have driven some beneficiaries to act to keep their Part D plan, which would have triggered a disenrollment or opt out of Cal MediConnect without the beneficiary actively choosing to disenroll or opt out. DHCS developed educational materials to insert into beneficiary mailings. Medicare also was ultimately able to update their beneficiary Part D mailings to better explain the transition.

#7 Cal MediConnect plans are coordinating LTSS, but more needs to be done for those who need personal care assistance. A key feature of the demonstration is to have CMC plans manage long-term services and supports (LTSS), creating financial incentives for plans to privilege home- and community-based services over more expensive institutionalization. While the data shows that CMC plans are beginning to have an impact on the non-medical needs of beneficiaries with disabilities, there is more to be done. A quarter of CMC beneficiaries said that their new plan had done something to make it "safer or easier" to live in their home, citing things like home modification, assistive technology, transportation, and additional personal assistance. They received these benefits either directly or due to intervention from their CMC plan. Despite this, 34 percent of CMC beneficiaries with functional limitations report having unmet needs for personal assistance services. Even those who are already getting Medi-Cal–funded in-home supportive services (IHSS), 32 percent still have unmet needs in this area. Though unmet needs for personal assistance are significantly less for CMC beneficiaries than those in non-demonstration counties, unmet needs are still too high (see Tables 50 to 53).

In this study, only 35 percent of CMC beneficiaries who were using LTSS (including IHSS, Community-Based Adult Services [CBAS], or the Multipurpose Senior Services Program [MSSP]) said the plan had asked them about it; and only 8 percent of those who needed personal assistance said that their LTSS had changed in any way because of their enrollment in a CMC health plan. Though it is possible that plans are facilitating services in ways that beneficiaries are unaware of, these results suggest that plans can be more proactive in addressing LTSS, especially with beneficiaries who have functional limitations and who rely on personal assistance services (see Tables 54 to 55).

- ***Insight: While CMC plans are responsible for coordinating and paying for LTSS, they were not granted the authority to authorize services such as IHSS, which is still authorized by county social services. Despite this limitation, CMC health plans can do more to facilitate needed LTSS by ensuring that any unmet needs are identified and addressed in beneficiary assessments.***
- ***Recommendation: Data on referrals made to home and community-based services by health plans should be analyzed to assess areas where CMC plans are making an impact on LTSS access and areas where referral to these services could be improved.***

DHCS Comment: DHCS is taking several steps to encourage broader use of LTSS services. DHCS is working with stakeholders to standardize new Health Risk Assessment questions designed to prompt referrals for non-medical or LTSS needs. These new questions will reflect best practices developed by plans with high rates of LTSS referrals. DHCS recently hosted a best practices meeting with the Cal MediConnect plans to discuss how to improve LTSS referrals. Additionally, DHCS is strengthening data collection around LTSS referrals to better track how effectively plans are linking beneficiaries to needed services. This information will allow for a better understanding of how and why Cal MediConnect plans are identifying a LTSS need and the services to which they are providing referrals. For more information on this effort, check here.

#8 Care coordination from Cal MediConnect plans is working well for beneficiaries who receive it. Beneficiaries in Cal MediConnect are more likely to have a care coordinator than those in non-CCI counties and those who opted out. There is some evidence that CMC care coordination is working well; those who have a care coordinator were more likely to be satisfied with their CMC benefits and knowledgeable about new benefits, such as transportation. Of those who experienced a disruption in care after the transition, enrollees with a CMC care coordinator were more likely to have those disruptions resolved than those with no care coordinator (see Tables 56 to 60).

However, it is unclear if care coordination through CMC is reaching individuals who need it most. Though risk stratification was used by CMC plans to identify those who might benefit from care coordination, the only characteristic that predicted receiving CMC care coordination, according to survey data, was utilization of behavioral health. Those in poor physical health and those with functional limitation (both characteristics that predict more disruptions in care) were not more likely to get CMC care coordination. Furthermore, almost half of those in CMC who were not using a care coordinator were unaware that the service was available (see Tables 61 to 62).

- ***Recommendation: Further examination of risk stratification and other pathways to CMC care coordination are needed to ensure that care coordination is being provided to those who would benefit most. Additional messages about the availability of care coordination for beneficiaries in notices and enrollment materials could increase awareness of this service among those who need it.***

DHCS Comment: In response to these results, DHCS will begin collecting more data from health plans on the extent to which individualized care plans and interdisciplinary care teams are being completed, utilized, and executed to help better understand care coordination in CMC and drive program improvements where needed.

Conclusion:

This is a high-level summary of survey data from beneficiaries about their experiences in Cal MediConnect. Comparison groups of beneficiaries who opted out of the program, and those in non-demonstration counties allowed for comparison across groups. Ongoing analysis will continue to identify ways that the Cal MediConnect program is benefiting beneficiaries, and ways that the program can be improved. A follow-up survey with these same beneficiaries will be conducted in 2017, allowing us to analyze how experiences with CMC, including: access to care, quality of care, and coordination of care for beneficiaries continue to evolve over time.

For questions or comments, please contact Carrie Graham, PhD clgraham@berkeley.edu.

APPENDIX 1: TELEPHONE SURVEY METHODOLOGY

This evaluation of California's dual financial alignment demonstration (the Coordinated Care Initiative or CCI) included a telephone survey with 2,139 dual eligible beneficiaries, including those who were enrolled in the program, those who were eligible but opted out/disenrolled, and those who were in non-demonstration (non-CCI) counties. This survey, conducted by researchers at the University of California, examined beneficiaries' experiences with access to care, quality of care, and coordination of care comparing those enrolled in Cal MediConnect (CMC) health plans with those not in the program. Researchers used a participatory process to engage state policymakers and stakeholders, including the California Department of Health Care Services (DHCS), representatives from disability advocacy organizations, CMC health plans, providers, and other organizations that serve dually eligible beneficiaries, in all phases of the evaluation including planning, priority setting, evaluation design, questionnaire development, accommodations to improve accessibility, data collection procedures, and interpretation of results. Researchers worked closely with the DHCS to determine evaluation priorities that would inform the future of integrated Medicare and Medicaid in California. The procedures for the study were approved by the University of California, San Francisco's Human Research Protection Program (#15-16186), the California Health and Human Services Agency's Committee for the Protection of Human Subjects (#15-01-1853) and Data and Research Committee (#15-03-01).

Sampling and Data Cleaning

DHCS Sampling:
Two datasets with beneficiary data were pulled by the DHCS for the telephone survey. The first was a complete list of CCI eligible beneficiaries in CCI counties, including San Mateo, Santa Clara, San Diego, Los Angeles, San Bernardino, and Riverside Counties.[1] Both those who were enrolled and those who opted out/disenrolled were included.[2] The second dataset included beneficiaries with similar characteristics in nine non-CCI counties.[3] Beneficiaries were eligible to be included in these datasets if they:

- Had full eligibility for Medicare Part A and Part B coverage and full eligibility for Medi-Cal between April 2014 and July 2015;
- Were aged 21 or over since those under 21 are not eligible for the CCI;
- Identified English, Spanish, ASL, or other sign languages as their primary language, or were missing the language variable (we assumed a lot of beneficiaries might be missing data for this variable because they are English speakers);
- Additionally, beneficiaries from the CCI counties were included if they:
    - Had an Aid Code that qualified them as eligible for the CCI/Cal MediConnect;

[1] Orange County was not included due to late enrollment.
[2] Eligibility criteria announced to the public can be found on the DHCS webpage: http://www.dhcs.ca.gov/Pages/CCI-Info-Bene.aspx#1.
[3] Counties were only included in the non-CCI sample if they had Medi-Cal managed care before the 2014 rural expansion, including Alameda, Contra Costa, Fresno, Kern, San Francisco, San Joaquin, Stanislaus, Tulare, and Sacramento Counties.

- Did not reside in one of the following San Bernardino zip codes 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 93592, and 93558 OR Riverside County zip 92225, 92226, 92239 OR Los Angeles zip code 90704;
- Were eligible to enroll in Cal MediConnect plans during the months of April 2014 through July 2015;
- Were not exempt from passive enrollment;
- Were not disqualified from Cal MediConnect because of a change to their status (such as losing Medi-Cal benefits, which would result in disenrollment from Cal MediConnect);
- Were enrolled in Medi-Cal for at least 6 months before transitioning to Cal MediConnect;
- Did not have Other Health Coverage code of C (CHAMPUS Prime HMO), G (CDCR Medi-Cal Parolee Plan, formerly American General), I (Public Institution Coverage, formerly Metropolitan Life), P (PHP/HMOs and EPO (Exclusive Provider Option) not otherwise specified), V (any carrier other than above, includes multiple coverage, formerly Variable), or 9 (Healthy Families);
- Did not have CO-ENRL-EXCL-IND code of N (beneficiary is in MSSP and is a Veterans' Home resident - not eligible for Cal MediConnect or MLTSS enrollment), O (beneficiary is in a 1915 (c) waiver and not eligible for Cal MediConnect enrollment, but is included in MLTSS), P (beneficiary is in a 1915 (c) waiver and a Veterans' Home resident and not available for Cal MediConnect or MLTSS enrollment), V (beneficiary is a Veterans' Home resident - not eligible for Cal MediConnect or MLTSS enrollment), D (beneficiary is in a DD waiver - not available for Cal MediConnect enrollment, but is eligible for MLTSS) or I (beneficiary is in an ICF DD facility and not available for Cal MediConnect or MLTSS enrollment);
- Did not have HCO-ESRD-IND of "Y" (except for San Mateo county);
- Were not on the ICF-DD Development CIN Exclusion List.

UC Data Cleaning:

The datasets pulled by the DHCS contained 162,792 CCI records, and 240,404 non-CCI records.

After transfer of the datasets, further data cleaning was conducted by the University of California's researchers using the following exclusion criteria:

- Language flag: Beneficiaries who were missing the language variable were excluded. The number was very small, and we could not tell whether the beneficiaries speak English or not, so we decided to exclude them.
- State flag: Beneficiaries not living in California were excluded.
- Zip code flag: Beneficiaries not having CCI/non-CCI county zip codes were excluded.
- Same name & birthday flag: Records with the same name and birthday were assumed to be duplicate records. For each set of duplicates, all records were excluded except for one record that was randomly chosen.
- Same name & address flag: Records with the same name and address were assumed to be duplicate records. For each set of duplicates, all records were excluded except for one record that was randomly chosen.

- Duplicate or invalid address flag: For each set of records with the same address, all were excluded except for one randomly chosen record. Same address is an indication of beneficiaries living in the same residence. To ensure that survey participants were independent of each other, we decided to keep only one record of the duplicates. However, in cases where we identified the address as a residential care facility, a hotel, a hospital, or a church, we did not exclude any records, since beneficiaries living in the same facility had a smaller chance of influencing one another's opinions compared with beneficiaries living together. Records with an incomplete or invalid address were excluded from the sample through a manual screening process.
- Bad phone number flag: Beneficiaries with a missing or invalid phone number (e.g., 000-000-0000 or 999-999-9999) were excluded.
- Same phone number flag: Records with the same phone number were excluded except for one randomly chosen record from each set. Same phone number is an indication of beneficiaries living in the same residence.
- Medi-Cal flag: Beneficiaries enrolled in Medi-Cal for less than 6 months were excluded.
- Field flag: CCI Beneficiaries who were included in the Field Research Rapid Cycle polling[4] were excluded to avoid survey fatigue.

Number of beneficiaries for each flag:

	CCI dataset N = 162,792	NON-CCI dataset N = 240,404
Language flag	24 (0.00%)	1 (<0.01%)
State flag	503 (0.31%)	249 (0.12%)
Zip code flag	674 (0.41%)	582 (0.29%)
Same name & birthday flag	7 (<0.01%)	6 (<0.01%)
Same name & address flag	19 (0.01%)	26 (0.01%)
Duplicate or invalid address flag	14,056 (8.63%)	311,80 (15.25%)
Bad phone number flag	1,393 (0.86%)	2,726 (1.33%)
Same phone number flag	15,035 (9.24%)	23,111 (11.31%)
Medi-Cal flag	2,961 (1.82%)	5,234 (2.56%)
Field flag	33,791(20.76%)	N/A

After dataset cleaning described above, there were a total of 109,617 records remaining in the CCI dataset and 162,512 records remaining in the non-CCI dataset.

Pilot sampling:
Two hundred among the 109,617 CCI beneficiaries and 100 among the 162,512 non-CCI beneficiaries were randomly selected for a pilot test. These pilot test beneficiaries were excluded from further sampling.

Phone purging:

[4] More information about the Field Rapid Cycle polling can be found on The Scan Foundation's website: http://www.thescanfoundation.org/evaluating-medicare-medicaid-integration.

Random samples of 10,000 CCI beneficiaries and 5,000 non-CCI beneficiaries were drawn after flagged beneficiaries were excluded. These phone numbers were run through an automated program that flagged the following:

- Records containing pager numbers
- Records containing inactive cell phone
- Records containing business, fax or modem, non-productive, and invalid landline phone numbers

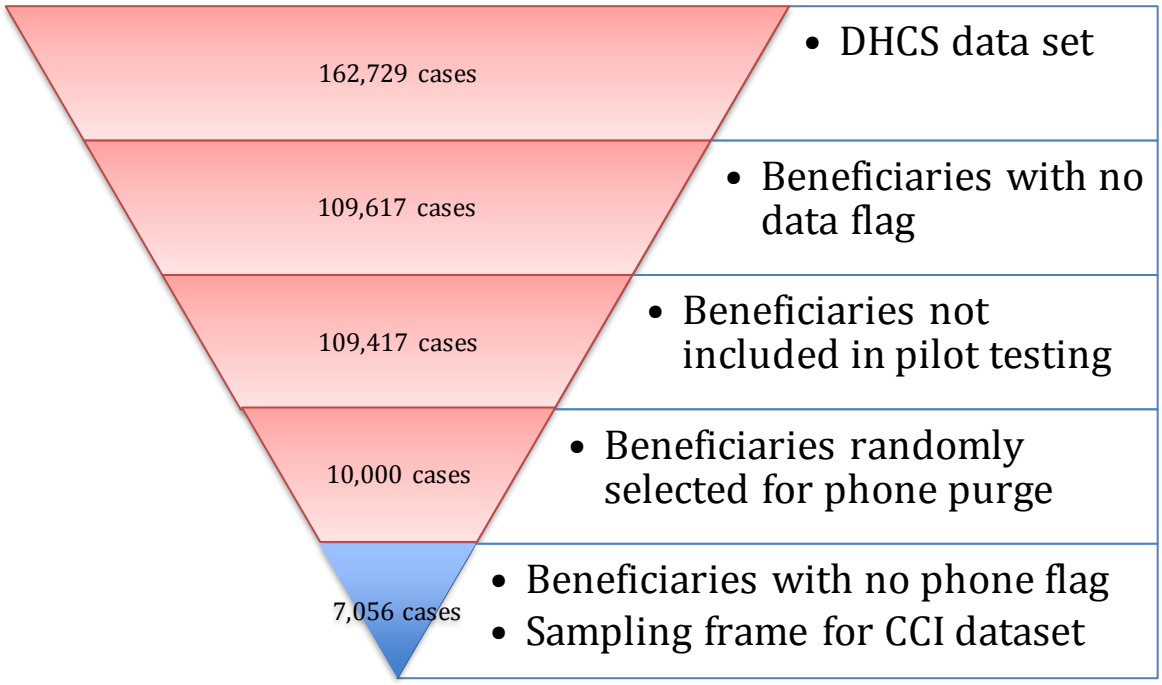
Beneficiaries with one of the above flags were excluded from further sampling.

Number of beneficiaries with each type of phone flag:

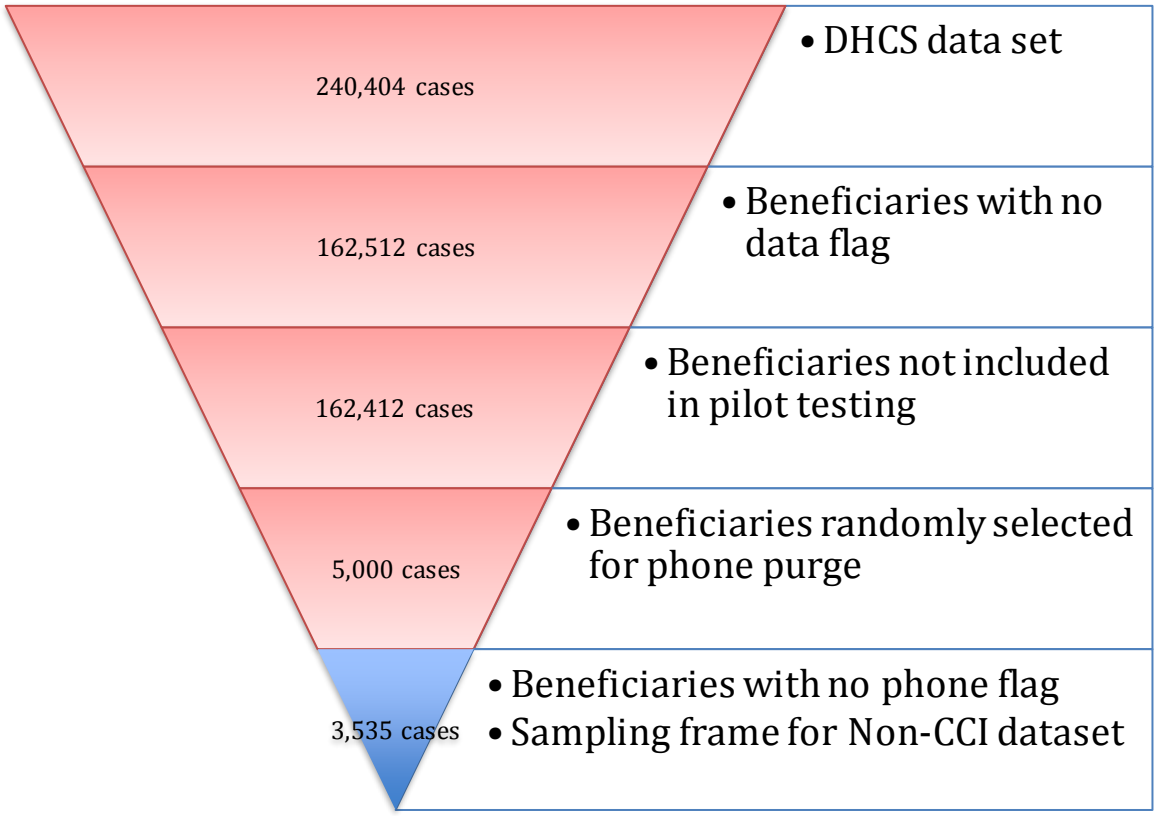
	CCI dataset N = 10,000	NON-CCI dataset N = 5,000
Pager number flag	6 (0.06%)	2 (0.04%)
Inactive cell phone flag	637 (6.37%)	347 (6.94%)
Business & invalid phone flag	2,301 (23.01%)	1,116 (22.32%)
Total phone flags		
• 0 flags	7,056 (70.56%)	3,535 (70.70%)
• 1 flags	2,944 (29.44%)	1,465 (29.30%)

The final sample sent to our telephone survey call center contained 7,056 cases in the CCI dataset and 3,535 records in the non-CCI dataset. See the following figures for the sampling design.

CCI Sampling Frame



Non-CCI Sampling Frame



Sample Size: Power Calculation

It was determined that the telephone survey would be administered to 1,400 dually eligible CCI beneficiaries and to a comparison group of 700 dually eligible beneficiaries in non-CCI counties. The sample size of 1,400 beneficiaries was needed to ensure that we would be able to detect, with 95% confidence, a 5-percentage-point difference in typical measures of satisfaction with services between (1) opt-outs and Cal MediConnect beneficiaries; and (2) people who use long-term services and supports (LTSS) and those who do not. To determine this sample size, we conducted a power calculation using results from Graham's (2014) study of seniors and people with disabilities (SPD) in mandatory Medi-Cal managed care.[5] Using those results as a basis, we hypothesized that 20% of Cal MediConnect beneficiaries would report that their care through Cal MediConnect is better than that under fee-for-service (the same proportion reporting this in the SPD study) and that 15% percent of beneficiaries who opted out would report a similar improvement. For this example, the sample size would be sufficient to detect that difference as significant. Furthermore, the sample size proposed is also sufficient to detect a 5-percentage-point difference in responses to a standard measure of access to care. For example, according to the California Health Interview Survey, 20% of California dual eligible beneficiaries report that they delayed or went without needed health care, including medications, in the prior 12 months.[6] We hypothesize that that proportion would remain the same in the non-CCI counties but improve to 15% in the CCI counties; such a difference would be detectable in the proposed survey with 95% confidence.

Participant Recruitment, Screening and Informed Consent

Recruitment:
Beneficiaries on the cleaned lists were randomly selected for participation. Potential participants were mailed a recruitment letter informing them that they had been selected to participate in a 30-minute telephone survey on their health care. Contact information, including a phone number, a relay communication service number, a text message number, and an email address, was provided so that potential participants had the opportunity to contact researchers ahead of time to either set up any communication accommodations (relay call, text, or email) or to decline to be interviewed. A week after the recruitment letter was sent, interviewers began calling these potential participants. After three calls without reaching a household member, a voice message was left, if possible. If no response was heard after two to three days, more calls were attempted at different times of day and evening. A second voice message was left during the eighth attempt, and a third voice message was left during the twelfth attempt. If a potential participant answered the phone but refused to participate, they were not called again. Potential participants were called until they either were reached by phone to either agree to participate or refuse, or until 16 attempts to contact them was made.

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[5] Graham, C. (2014, April). *In transition: Seniors and people with disabilities reflect on their move to Medi-Cal managed care.* Retrieved from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20T/PDF%20TransitionSPDsMoveMMC.pdf

[6] California Health Interview Survey. www.ask.chis.ucla

Once an interviewer reached a potential participant, the interviewer read a brief description of the telephone survey to the beneficiary, asked about the need for communication assistance, and requested the beneficiary's permission to conduct the screening. Potential participants were also asked to choose between English and Spanish as the language for the interview. If a potential participant could not communicate via phone or using alternative methods, or if he/she preferred having someone else taking the survey on his/her behalf, interviews asked for a proxy who helps the potential participant make health care decisions. Interviewers assured potential participants that their responses would be kept confidential.

Twenty-one beneficiaries were not qualified to participate because of cognitive impairment; 178 beneficiaries were either deceased, in hospice, in a nursing home (but with a residential address or phone number on the DHCS record), or out of the country and thus could not be contacted; one person refused to be/find a proxy; and 10 beneficiaries did not have a proxy.

Screening:
After obtaining permission to conduct screening, interviewers screened all potential participants and excluded them from the study for the following reasons:

- Potential participants received all their health care services from the Veteran's Administration (n = 26);
- Potential participants were not receiving both Medicare and Medi-Cal benefits (n = 118);
- Potential participants were currently living outside of the six CCI counties or the nine non-CCI counties (n = 20)

In addition, those in non-CCI counties were screened out for the following reasons:[7]

- Potential participants were a participant in the Program of All-Inclusive Care for the Elderly (PACE) (n = 3);
- Potential participants received Share of Cost Medi-Cal (n = 69);
- Potential participants lived in a veteran's home in California (n = 4);
- Potential participants received services for a developmental disability from a Regional Center (n = 55).

Potential participants meeting these exclusion criteria were thanked and recorded as ineligible for the telephone survey.

Additionally, proxies had to be above the age of 18 (n = 2 were not) and express confidence in responding to the survey according to the beneficiary's wishes (n = 2 did not).

Once eligibility had been established, the potential participants from CCI counties were asked a series of questions designed by the research team to confirm or update their status as a Cal MediConnect beneficiary or an opt out/disenrolled.

Informed consent:

[7] The CCI beneficiaries were not asked these questions because the state had used the information as part of the CCI sampling criteria.

After screening, eligible potential participants were invited to take part in the study. If a potential participant refused, he or she was not contacted again. If interested in taking part, a potential participant went through the informed consent process (see end of Appendix 1) and was provided an opportunity to ask questions. The informed consent included a brief screening for cognitive impairment. Interviewers requested that those potential participants who failed the cognitive impairment screening invite a proxy to participate in the survey on his/her behalf. If the potential participant refused or did not have a proxy to designate, they were recorded as ineligible for the telephone survey (n = 59).

Eligible participants moved forward to be interviewed and followed different skip patterns depending on their status (Cal MediConnect beneficiaries, opt-outs, or non-CCI beneficiaries). Breaks were provided if needed, and several fatigue probes were utilized during the survey to ensure survey quality.[8] The survey could also be conducted during more than one session if needed. At the end of the survey, interviewers sent the participant their choice of a $10 gift card from Safeway or a $10 gift card from Target as a token of thanks for their participation. If a proxy participated on behalf of a beneficiary, it was made clear that the gift card would be sent to the beneficiary. Lastly, interviewers asked permission to contact beneficiaries/proxies again in a year for a follow-up survey, and the best phone number to reach the beneficiaries/proxies was recorded.

The average length of the survey, from someone picking up the phone to the end of the survey, was 29.36 minutes. Response rate 3 (RR3) was 59.8% and Response rate 4 (RR4) was 63.9% based on the American Association for Public Opinion Research's (AAPOR) several approaches for calculating response rate. RR4 regards "Terminates (qualified but did not complete survey)" as responses, while RR3 does not.

In total, 1,386 potential participants refused to be surveyed. Non-response analyses revealed that refusals were more likely than participants to be opt-outs ($X^2(1)= 15.52$, $p < .001$) and speak English at home ($X^2(3)= 29.28$, $p < .001$), and they were less likely to have Medi-Cal managed care before the CCI transition ($X^2(1)= 18.00$, $p < .001$).

Survey Participant Characteristics

The telephone survey included 2,139 dually eligible beneficiaries or their health care proxies, with 744 in Cal MediConnect, 659 opted out, and 736 in non-CCI counties.

All surveys were conducted between January 2016 and March 2016. Efforts were made to make the survey as accessible as possible to individuals with a variety of disabilities or communication challenges. Potential participants were invited to contact researchers directly with requests for accommodations such as conducting the survey through relay communication, text or TTY. Three deaf potential participants set up video sign language/interpreter services with us, but two of them could not be reached at appointment times and one started and terminated because the survey took too long.

[8] "Are you feeling tired, or can we continue?" "Would you like to take a break? I can hold on." "There is no right or wrong answer to these questions."

Comparing the three groups, non-CCI beneficiaries were more likely to speak English at home, compared to CCI beneficiaries who were more likely to speak Spanish ($X^2(14)= 65.90$, $p < .001$). Not surprisingly, non-CCI beneficiaries were more likely to be Caucasian, as compared to more Hispanics/Latinos in CCI samples ($X^2(14)= 59.74$, $p < .001$). Non-CCI beneficiaries were also more likely to have been enrolled in Medi-Cal longer ($X^2(26)= 1808.45$, $p < .001$). Cal MediConnect beneficiaries' education levels tended to be lower ($X^2(16)= 46.92$, $p < .001$), and they lived with more adults in the household ($F(2)= 6.98$, $p = .001$). In addition, a lower percentage of Cal MediConnect beneficiaries had difficulty walking or climbing stairs ($X^2(2)= 23.74$, $p < .001$), dressing or bathing ($X^2(2)= 24.39$, $p < .001$), or doing errands alone such as visiting a doctor's office ($X^2(2)= 10.81$, $p = .005$). More Cal MediConnect beneficiaries had a care coordinator ($X^2(2)= 69.47$, $p < .001$), and their care coordinators were more likely to be someone from their health plans ($X^2(10)= 116.39$, $p < .001$). Opt-outs rated their health condition to be worse ($X^2(6)= 22.06$, $p = .001$), and a higher percentage of opt-outs used specialty care ($X^2(2)= 15.99$, $p < .001$) and services to assist with bathing, dressing, preparing meals, housework, or grocery shopping ($X^2(2)= 27.06$, $p < .001$).

The following differences were also found comparing Cal MediConnect beneficiaries with opt-outs through the data provided by the DHCS: LTSS usage ($X^2(1)= 42.82$, $p < .001$), IHSS usage ($X^2(1)= 36.39$, $p < .001$), and nursing facility usage ($X^2(1)= 14.78$, $p < .001$) between April 2013 to July 2014 were higher among opt-outs, while independent rehabilitation facility usage ($X^2(1)= 4.34$, $p < .001$) was higher among Cal MediConnect beneficiaries. Medi-Cal managed care enrollment before CCI was higher among Cal MediConnect beneficiaries ($X^2(1)= 207.86$, $p < .001$), and Cal MediConnect beneficiaries experienced the CCI transition earlier than opt-outs ($t(1401)= 3.88$, $p < .001$).

Finally, I want to let you know that this interview is completely voluntary. That means you decide whether or not you want to do it. You can skip any questions and you can stop the interview at any time. Whatever you decide, [your/R NAME's] Medi-Cal or Medicare benefits will not be affected.

So, just to be sure my explanation was clear, when I say your participation is COMPLETELY VOLUNTARY, what does that mean to you, in your own words?

[EXAMPLES OF ACCEPTABLE ANSWERS]
- I can decide to take part or not to take part. → CONTINUE TO C-2
- I can refuse to take part if I want. → CONTINUE TO C-2
- I do not have to do this. → CONTINUE TO C-2
- I can do this if I want. → CONTINUE TO C-2
- No one can take away my benefits if I refuse. → CONTINUE TO C-2

[EXAMPLES OF UNACCEPTABLE ANSWERS]
- It is voluntary. [PROBE]: What does that mean, in your own words?
- Don't know, or refuses to answer.

IF R'S ANSWER IS ACCEPTABLE, CODE "ACCEPTABLE" BELOW.

IF R'S ANSWER IS UNACCEPTABLE, BUT SEEMS TO UNDERSTAND THE CONCEPT OF VOLUNTARY, JUST DOES NOT UNDERSTAND WHY WE WANT HIM/HER TO REPHRASE THE CONCEPT, PROBE: "**Is this something you have to do or something you can do if you want to?**"

IF R'S ANSWER IS UNACCPETABLE AND DOES NOT SEEM TO UNDERSTAND THE CONCEPT OF VOLUNTARY, TRY ONCE MORE USING THE FOLLOWING SCRIPT:

OK, let's try that again. Taking part in this interview is completely voluntary. That means you decide whether or not you want to do it. You can skip any questions and you can stop the interview any time. Whatever you decide, [your/R NAME's] Medi-Cal or Medicare benefits will not be affected. To make sure my explanation was clear, in your own words, what does voluntary mean to you?

- Acceptable answer → CONTINUE TO C-2
- Unacceptable answer → <u>GO TO PROXY IDENTIFICATION SCRIPT</u>

IF ALREADY SPEAKING WITH A PROXY OR A PROXY IS NOT AVAILABLE, SAY: **I'm sorry, but you are not eligible to participate. That is all the questions we have for you today. Thank you for your time.** [<u>RECORD AS INELIGIBLE</u>].

C-2. Do you voluntarily agree to participate?

- Yes → CONTINUE TO C-3

- No → ASK: All right. That's fine. Do you have any questions or concerns you'd like to talk about?
  - No → OK, then that is all for today. Thank you for your time. [RECORD AS REFUSED TO PARTICIPATE]
  - Yes → RESPOND TO QUESTIONS/CONCERNS AS APPROPRIATE. THEN ASK: **Now that we've talked about that, would you like to voluntarily to agree to participate or are you interested in participating?**
    - VOLUNTARILY AGREES → CONTINUE TO C-3
    - STILL NOT INTERESTED → OK, then that is all for today. Thank you very much for your time. [RECORD AS REFUSED TO PARTICIPATE]

If you have any questions about the research at a later time we will be sending you a letter with your gift card that includes both the phone number of the lead researcher Carrie Graham, and contact information for the UC San Francisco Office for Protection of Human Subjects.

[PROMPT: If the respondent says they would prefer to the get the information right now rather than waiting for the letter, say: **If you have any questions about the research at a later time, you can contact the lead investigator, Carrie Graham, at 1-510-982-6026. If you have questions about your rights as a participant you can contact the UC San Francisco Office for Protection of Human Subjects at 1-415-476-1814.]**

[CCI CONTINUES; NON-CCI & UNAWARE CMC & UNAWARE MMC GO TO PRIMARY CARE]

APPENDIX 2: DATA TABLES FOR TELEPHONE SUREY KEY FINDINGS

Table 1

Overall, are [you/R] currently satisfied or dissatisfied with [your/R's] health insurance benefits?

	CMC (*n*=716)		Opt Out (*n*=629)		NON-CCI (*n*=708)		Chi-square test	df	*p*
Satisfied	640	(89.4%)	561	(89.2%)	626	(88.4%)	.376	2	0.829
Dissatisfied	76	(10.6%)	68	(10.8%)	82	(11.6%)			

Table 2

How would you rate the overall quality of care [you are/R is] currently receiving?

	CMC (*n*=728)		Opt Out (*n*=645)		NON-CCI (*n*=718)		Chi-square test	df	*p*
Excellent	302	(41.5%)	286	(44.3%)	355	(49.4%)	11.288	6	0.080
Good	304	(41.8%)	254	(39.4%)	263	(36.6%)			
Fair	105	(14.4%)	84	(13.0%)	83	(11.6%)			
Poor	17	(2.3%)	21	(3.3%)	17	(2.4%)			

Table 3

Since you switched to CCI, would you say your overall quality of care is better, about the same, or worse than it was before you switched?

	CMC (*n*=593)		Opt Out (*n*=360)		Chi-square test	df	*p*
Better	216	(36.4%)	76	(21.1%)	25.038	2	<0.001
About the same	339	(57.2%)	259	(71.9%)			
Worse	38	(6.4%)	25	(6.9%)			

Table 4

Reasons Why CMC Plan Is Better (n=261)

Description	n	%
Increased speed with which care or information about plan is delivered relative to previous plan (i.e., decreased wait time)	59	22.6
Improved quality of care (i.e., doctors or services are better, doctors' knowledge about one's condition is better)	54	20.7
Received all the care or services needed	48	18.4
Increased ease with which information is obtained	36	13.8
Increased access to doctors or services (i.e., able to get what one hasn't before)	28	10.7
Increased ease with which medications, specialists, surgeries, or other acute care services are authorized or referred	28	10.7
Increased availability of and access to prescription drugs	22	8.4
Increased coverage of services	21	8
No reported change (i.e., same doctor, hospital, plan, etc.)	14	5.4
Stayed with the same doctor from previous plan	11	4.2
Lower out-of-pocket costs	10	3.8
Increased autonomy (i.e., ability to choose doctors, go to any medical office they want, get medications)	10	3.8
Improved health conditions	9	3.4
Closer proximity to doctor, clinics, or pharmacies	7	2.7
Other (i.e., better physical therapy or occupational therapy services, language support)	5	1.9
Increased coordination of care between providers	3	1.1
Improvements to:		
Behavioral health services or providers	2	0.8
Long-term services and support (i.e., personal care, homemaking, meals)	1	0.4
Acute care and services	5	1.9

Primary care providers	8	3.1
Specialty care providers	31	11.9
Dental care or services	5	1.9
Vision care or services	9	3.4
Durable medical equipment and supplies	8	3.1
Transportation services	7	2.7

Table 5

Since you switched to CCI, would you say your overall quality of care is better, about the same, or worse than it was before you switched?

	Less than 12 months (*n*=116)		13-18 months (*n*=259)		Over 19 months (*n*=218)		Gamma test	*p*
Better	34	(29.3%)	89	(34.4%)	93	(42.7%)	-.139	0.029
About the same	77	(66.4%)	151	(58.3%)	111	(50.9%)		
Worse	5	(4.3%)	19	(7.3%)	14	(6.4%)		

Table 6

After you switched to CCI, could [you/he/she] still see the same primary care provider [you were/he was/she was] seeing before, or did [you/he/she] change to a new primary care provider?

	CMC (*n*=561)		Opt Out (*n*=339)		Chi-square test	df	*p*
Still able to see same primary care provider	429	(76.5%)	290	(85.5%)	10.832	1	0.001
Had to change to a new primary care provider	132	(23.5%)	49	(14.5%)			

Table 7

When you switched to CCI, could [you/he/she] still see…

	CMC (*n*=333)		Opt Out (*n*=258)		Chi-square test	df	*p*
All old specialists	220	(66.1%)	204	(79.1%)	13.761	2	0.001
Some old specialists	67	(20.1%)	26	(10.1%)			
None of the old specialists	46	(13.8%)	28	(10.9%)			

Table 8

When [you/R] switch to CCI, did [your/his/her] prescription medications all stay the same, or did [you/he/she] have to change some or all of [your/his/her] prescription medications?

	CMC (*n*=552)	Opt Out (*n*=333)	Chi-square test	df	*p*
All prescription medications stayed the same	406 (73.6%)	266 (79.9%)	4.577	2	0.101
Had to change some medications	136 (24.6%)	62 (18.6%)			
Had to change all medications	10 (1.8%)	5 (1.5%)			

Table 9

In the last 6 months, how often were [you/R] able to go to the hospital [you/R] wanted to go to?

	CMC (*n=157*)	Opt Out (*n*=150)	NON-CCI (*n=156)*	Chi-square test	df	*p*
All the time	120 (76.4%)	120 (80.0%)	124 (79.5%)	1.232	4	0.873
Some of the time	23 (14.6%)	18 (12.0%)	22 (14.1%)			
Never	14 (8.9%)	12 (8.0%)	10 (6.4%)			

Table 10

Overall, are [you/R] currently satisfied or dissatisfied with [your/R's] health insurance benefits?

	Still able to see same primary care provider (*n*=707)	Had to change to a new primary care provider (*n*=176)	Chi-square test	df	*p*
Very dissatisfied	28 (4.0%)	17 (9.7%)	15.842	3	0.001
Somewhat dissatisfied	28 (4.0%)	12 (6.8%)			
Somewhat satisfied	252 (35.6%)	69 (39.2%)			
Very satisfied	399 (56.4%)	78 (44.3%)			

Table 11

Overall, are [you/R] currently satisfied or dissatisfied with [your/R's] health insurance benefits?

	All old specialists (*n*=417)	Some old specialists (*n*=93)	None of the old specialists (*n*=70)	Chi-square test	df	*p*
Very dissatisfied	10 (2.4%)	11 (11.8%)	9 (12.9%)	41.603	6	<0.001
Somewhat dissatisfied	11 (2.6%)	7 (7.5%)	6 (8.6%)			
Somewhat satisfied	134 (32.1%)	39 (41.9%)	19 (27.1%)			
Very satisfied	262 (62.8%)	36 (38.7%)	36 (51.4%)			

Table 12

Overall, are [you/R] currently satisfied or dissatisfied with [your/R's] health insurance benefits?

	All prescription medications stayed the same (*n*=660)	Had to change some medications (*n*=193)	Had to change all medications (*n*=14)	Chi-square test	df	*p*
Very dissatisfied	29 (4.4%)	13 (6.7%)	2 (14.3%)	28.950	6	<0.001
Somewhat dissatisfied	22 (3.3%)	15 (7.8%)	0 (0.0%)			
Somewhat satisfied	221 (33.5%)	88 (45.6%)	7 (50.0%)			
Very satisfied	388 (58.8%)	77 (39.9%)	5 (35.7%)			

Table 13

(Cal MediConnect R who changed doctor(s)) Did you know that [you/R] could file a continuity of care request?

	CMC (*n*=209)
Yes	56 (26.8%)
No	153 (73.2%)

Table 14

Since [you/R] switched to CCI, has getting appointments with [your/R's] primary care provider been…

	CMC (*n*=560)		Opt Out (*n*=344)		Chi-square test	df	*p*
Easier	156	(27.9%)	74	(21.5%)	4.523	2	0.104
About the same	362	(64.6%)	242	(70.3%)			
More difficult	42	(7.5%)	28	(8.1%)			

Table 15

In the past 6 months, how many days did you usually have to wait for an appointment when you needed care right away?

	CMC (*n*=561)		Opt Out (*n*=517)		NON-CCI (*n*=594)		Chi-square test	df	*p*
Same day	225	(45.5%)	250	(48.4%)	301	(50.7%)	11.147	8	0.194
1 day	62	(11.1%)	68	(13.2%)	71	(12.0%)			
2 to 3 days	78	(13.9%)	65	(12.6%)	85	(14.3%)			
4 to 7 days	43	(7.7%)	47	(9.1%)	40	(6.7%)			
More than 7 days	123	(21.9%)	87	(16.8%)	97	(16.3%)			

Table 16

Since [you/R] switched to CCI, has getting appointments with [your/R's] specialists been…

	CMC (*n*=379)		Opt Out (*n*=276)		Chi-square test	df	*p*
Easier	99	(26.1%)	74	(22.5%)	8.115	2	0.017
About the same	234	(61.7%)	242	(71.0%)			
More difficult	46	(12.1%)	28	(6.5%)			

Table 17

In the last six months, how often was it easy to get appointments with specialists?

	CMC (*n*=427)		Opt Out (*n*=415)		NON-CCI (*n*=401)		Chi-square test	df	*p*
Never	29	(9.1%)	28	(6.7%)	27	(6.7%)	8.899	6	0.179
Sometimes	74	(17.3%)	53	(12.8%)	70	(17.5%)			
Usually	62	(14.5%)	80	(19.3%)	67	(16.7%)			
Always	252	(59.0%)	254	(61.2%)	237	(59.1%)			

Table 18

Since [you/R] switched to CCI, has getting appointments with mental health care providers been…

	CMC (*n*=135)		Opt Out (*n*=86)		Chi-square test	df	*p*
Easier	32	(23.7%)	14	(16.3%)	1.809	2	0.405
About the same	83	(61.5%)	59	(68.6%)			
More difficult	20	(14.8%)	13	(15.1%)			

Table 19

In the last six months, how often was it easy to get your prescription medications?

	CMC (*n*=674)		Opt Out (*n*=606)		NON-CCI (*n*=676)		Chi-square test	df	*p*
Always easy	528	(78.3%)	436	(71.9%)	475	(70.3%)	14.797	4	0.005
Sometimes easy	126	(18.7%)	137	(22.6%)	161	(23.8%)			
Never Easy	20	(3.0%)	33	(5.4%)	40	(5.9%)			

Table 20

Since [you/R] switched to CCI, has getting the equipment/supplies [you need/R needs] been…

	CMC (*n*=308)		Opt Out (*n*=209)		Chi-square test	df	*p*
Easier	79	(25.6%)	26	(12.4%)	13.453	2	0.001
About the same	183	(59.4%)	145	(69.4%)			
More difficult	46	(14.9%)	38	(18.2%)			

Table 21

Since [your/R's] switched to CCI, have [your/R's] dental benefits been better, about the same, or worse?

	CMC (*n*=324)		Opt Out (*n*=218)		Chi-square test	df	*p*
Better	76	(23.5%)	27	(12.4%)	18.020	2	<0.001
About the same	161	(49.7%)	147	(67.4%)			
Worse	87	(26.9%)	44	(20.2%)			

Table 22

Since [your/R's] switch to CCI, has [your/R's] vision benefits been better, about the same, or worse?

	CMC (*n*=375)		Opt Out (*n*=225)		Chi-square test	df	*p*
Better	99	(26.4%)	27	(12.0%)	18.250	2	<0.001
About the same	240	(64.0%)	167	(74.2%)			
Worse	36	(9.6%)	31	(13.8%)			

Table 23

Since you switched to CCI, [have you/has R] used the emergency room…

	CMC (*n*=523)		Opt Out (*n*=315)		Chi-square test	df	*p*
More	44	(8.4%)	17	(5.4%)	6.320	2	0.042
About the same	304	(58.1%)	209	(66.3%)			
Less	175	(33.5%)	89	(28.3%)			

Table 24

Did [you/R] get a letter in the mail letting you know about the Cal MediConnect Program?

	CMC (*n*=461)	Opt Out (*n*=309)	Chi-square test	df	*p*
Yes	304 (66%)	240 (78%)	12.27	1	<.001
No	157 (34%)	69 (22%)			

Table 25

(If a letter was received...) Thinking about the information in the letter/s, how useful was the information [you/R] got about the Cal MediConnect program?

	CMC (*n*=239)	Opt Out (*n*=201)	Chi-square test	df	*p*
Very useful	136 (57%)	59 (29%)	42.14	2	<.001
Somewhat useful	85 (36%)	93 (46%)			
Not at all useful	18 (8%)	49 (24%)			

Table 26

Did you know that Cal MediConnect plans will provide their members with up to 30 one way rides per year to the doctor or other health related appointments (picking up prescriptions/getting lab tests)?

	CMC (*n*=614)	Opt Out (*n*=353)	Chi-square test	df	*p*
Yes	307 (50%)	116 (33%)	26.79	2	<.001
No	307 (50%)	237 (67%)			

Table 27

Recommendations to Improve Notification Letter (n=189)

Description	n	%
Explain the program better in layman terms as the letter is unclear, nonspecific, vague, and confusing	58	30.7
Generally need more or specific information on what the program is about and how it works	45	23.8
Explain the benefits that will be newly covered or lost by in the new plan and show the differences between CMC and non-CMC programs	36	19.0
Vague response, such as "don't know" or "don't remember"	18	9.5
Explain whether or not recipients can keep their same doctors, prescriptions, pharmacy, hospital, etc.	17	9.0
Unrelated complaints about the letter or CMC	17	9.0
Provide a personalized letter, explaining how the program would affect the individual	14	7.4
Be clear that enrollment is not mandatory and opt-out is an option and provide alternatives	13	6.9
Summarize more as the letter is too lengthy and wordy	7	3.7
Explain the program via person, not letter	3	1.6
Provide letter in recipient's language of preference	3	1.6
Too much unnecessary paperwork attached to letter	2	1.1

Provide accurate information as the letter included misleading or inaccurate information	2	1.1
Explain if the plan would change the medication, equip or supplies the recipients need	1	0.5

Table 28

Because of switching to CCI, did you experience any delays or problems getting any of the care, services or supplies you need?

	CMC (*n*=608)		Opt Out (*n*=363)		Chi-square test	df	*p*
Yes	114	(18.8%)	79	(21.8%)	1.296	1	0.255
No	494	(81.3%)	284	(78.2%)			

Table 29

[Has that/have those] problem(s) been resolved or [is it/are they] still ongoing?

	CMC (*n*=108)		Opt Out (*n*=76)		Chi-square test	df	*p*
All problems resolved	38	(35.2%)	36	(47.4%)	3.080	2	0.214
Some problems resolved but not all	23	(21.3%)	11	(14.5%)			
None of the problems resolved	47	(43.5%)	29	(38.2%)			

Table 30

*Would you say that in general [your/R's] health is… * Because of switching to CCI, did you experience any delays or problem getting any of the care, services or supplies you need?*

	Yes (*n*=189)		No (*n*=763)		Chi-square test	df	*p*
Excellent	12	(6.3%)	70	(9.2%)	25.696	3	<0.001
Good	45	(23.8%)	275	(36.0%)			
Fair	81	(42.9%)	316	(41.4%)			
Poor	51	(27.0%)	102	(13.4%)			

Table 31

*[Do you/Does R] currently use any medical equipment or supplies? * Because of switching to CCI, did you experience any delays or problem getting any of the care, services or supplies you need?*

	Yes (*n*=193)		No (*n*=776)		Chi-square test	df	*p*
Yes, I use DME	131	(67.9%)	398	(51.3%)	17.154	1	<0.001
No, I don't use DME	62	(32.1%)	378	(48.7%)			

Table 32

*Number of disabilities (ranges from 0 to 6) * Because of switching to CCI, did you experience any delays or problems getting any of the care, services or supplies you need?*

	Yes (*n*=187)		No (*n*=751)		Chi-square test	df	*p*
Zero	19	(10.2%)	198	(26.4%)	58.361	6	<0.001
One	31	(16.6%)	163	(21.7%)			
Two	34	(18.2%)	140	(18.6%)			
Three	34	(18.2%)	117	(15.6%)			
Four	32	(17.1%)	83	(11.1%)			
Five	24	(12.8%)	42	(5.6%)			
Six	13	(7.0%)	8	(1.1%)			

Table 33

Areas in which Recipients Experienced Delays (n=179)

Description	n	%
Delay in obtaining medication	50	27.9
Delay in obtaining medical equipment or supplies	37	20.7
Delay in getting appointments or services	36	20.1
Difficulty with seeing specialists	26	14.5
Referral and authorization process	19	10.6
Delay in receiving dental services	18	10.1

Change in providers, medical group, or pharmacies	14	7.8
Improper handling of transition to new plan	11	6.1
Issues with payments, incurring additional or unexpected out-of-pocket costs	10	5.6
Delay in receiving vision services	9	5
Difficulty with seeing primary care providers	8	4.5
Lab tests or imaging work	6	3.4
Worsened quality of care	6	3.4
Delays in transportation	6	3.4
Difficulty finding an in-network provider	5	2.8
Difficulty receiving acute care (i.e., emergency room, hospital admission, surgery)	5	2.8
Delay in seeing mental health provider (i.e., psychiatrist, psychologist, therapist) or in receiving services from a mental health clinic or substance abuse program	3	1.7
Other (i.e., delays in physical therapy or occupational therapy services, language support)	3	1.7
Unaware of CMC enrollment	2	1.1
Issues with personal care, home care, IHSS	1	0.6

Table 34

*Do you have a care coordinator? * [Has that/have those] problem(s) been resolved or [is it/are they] still ongoing?*

	All or some problems resolved (*n*=97)		None of the problems are resolved (*n*=73)		Chi-square test	df	*p*
Yes, I have a care coordinator	34	(35.1%)	15	(20.5%)	4.271	1	0.039
No, I don't have a care coordinator	63	(64.9%)	58	(79.5%)			

Table 35

*Education (less than high school vs high school grads) * Because of switching to CCI, did you experience any delays or problems getting any of the care, services or supplies you need?*

	Yes (*n*=189)		No (*n*=758)		Chi-square test	df	*p*
Less than high school	66	(34.9%)	301	(39.7%)	1.462	1	0.227
High school grads	123	(65.1%)	457	(60.3%)			

Table 36

*How often [do you/does R] need to have someone help [you/R] when [you/R] read instructions, pamphlets, or other written material from [your/R's] doctor or pharmacist? * Because of switching to CCI, did you experience any delays or problems getting any of the care, services or supplies you need?*

	Yes (*n*=188)		No (*n*=765)		Chi-square test	df	*p*
Never	56	(29.8%)	285	(37.3%)	7.349	4	0.119
Rarely	27	(14.4%)	98	(12.8%)			
Sometimes	34	(18.1%)	159	(20.8%)			
Often	12	(6.4%)	46	(6.0%)			
Always	59	(31.4%)	177	(23.1%)			

Table 37

Beneficiary Gender

	CMC (*n*=744)		Opt Out (*n*=659)		Chi-square test	df	*p*
Female	426	(57.3%)	429	(65.1%)	9.025	1	0.003
Male	318	(42.7%)	230	(35.0%)			

Table 38

[Do you/Does R] have difficulty walking or climbing stairs?

	CMC (*n*=741)		Opt Out (*n*=656)		Chi-square test	df	*p*
Yes	394	(53.2%)	426	(64.9%)	19.875	1	<0.001
No	347	(46.8%)	230	(35.1%)			

Table 39

Aware vs. Unaware Status in CMC and Opt Out

	CMC (*n*=774)		Opt Out (*n*=659)	
Aware	623	(83.7%)	373	(56.6%)
Unaware	121	(16.2%)	286	(43.4%)

Table 40

Aware vs. Unaware Status by Age Groups

	Older Adults (*n*=398)		Younger Adults (*n*=261)		Chi-square test	df	*p*
Aware	208	(52.3%)	165	(63.2%)	7.704	1	0.006
Unaware	190	(47.7%)	96	(36.8%)			

Table 41

Aware vs. Unaware Status by Language

	English (*n*=467)		Spanish (*n*=191)		Chi-square test	df	*p*
Aware	289	(61.9%)	84	(44.0%)	17.701	1	<0.001
Unaware	178	(38.1%)	107	(56.0%)			

Table 42

Aware vs. Unaware Status by Education Level

	Below high school (*n*=255)		High school and above (*n*=387)		Chi-square test	df	*p*
Aware	126	(49.9%)	238	(61.5%)	9.147	1	0.002
Unaware	129	(50.6%)	149	(38.5%)			

Table 43

In the last six months, how often was it easy to get appointments with specialists?

	Aware (*n*=261)		Unaware (*n*=154)		Chi-square test	df	*p*
Never	16	(6.1%)	12	(7.8%)	12.490	3	0.006
Sometimes	24	(9.2%)	29	(18.8%)			
Usually	60	(23.0%)	20	(13.0%)			
Always	161	(61.7%)	154	(60.4%)			

Table 44

In the last six months, were there barriers that made it hard to get into a doctor's office?

	Aware (*n*=261)		Unaware (*n*=154)		Chi-square test	df	*p*
Yes	15	(6.2%)	26	(14.7%)	8.349	1	0.004
No	227	(93.8%)	151	(85.3%)			

Table 45

Main Reason Prompting Recipient to Opt Out of CMC (n=331)

Description	n	%
Specified reason		
Want to keep current doctor and not change providers	157	47.4
More benefits in current plan; CMC does not cover all needs; can see whichever doctor	60	18.1
Content with current plan; does not like CMC	48	14.5
Choices difficult to understand and complicated; not enough time to go through process of figuring plan out; letter was not informative enough; not aware of opt out	39	11.8
Ambiguous response, other	20	6
Dislike HMO plan vs. PPO	15	4.5
Advised by doctor or someone from doctor's office	9	2.7
Out-of-pocket expenses	9	2.7
Referral and authorization process	8	2.4
Greater distance from new provider would pose problems	6	1.8
Poor communication with plan; bad care attitudes via phone	5	1.5
Longer time to book appointments in CMC plan	4	1.2
In middle of treatment for acute illness (cancer) or had a surgery scheduled	3	0.9
Any reason applicable to:		
Specialty care	13	3.9
Primary care	11	3.3
Acute care, including hospitalization or emergency room	8	2.4
Behavioral health	7	2.1
Long term services and supports, including personal care, homemaking, meals, and transportation	7	2.1
Medications/prescriptions	3	0.9
Nursing home, rehabilitation facility	3	0.9

Durable Medical Equipment	1	0.3
Dental	1	0.3

Table 46

Did anyone advise [you/R] to or recommend that [you/R] opt out of Cal Medi-Connect?

	Opt Out (*n*=352)	
Yes	99	(28.1%)
No	253	(71.9%)

Table 47

If yes, who was it that advised or recommended that [you/R] opt out of Cal Medi-Connect?

	Opt Out (*n*=352)	
Your doctor	42	(44.7%)
Another healthcare worker (i.e., nurse, medical assistant, physician's assistant)	13	(13.8%)
Nursing home	2	(2.1%)
Benefits counselor	6	(6.4%)
A family member	4	(4.3%)
A friend	3	(3.2%)
Other specified	24	(25.5%)

Table 48

How easy or difficult was the process of opting out? Was it…

	Opt Out (*n*=332)	
Very easy	158	(47.6%)
Somewhat easy	80	(24.1%)
Somewhat difficult	55	(16.6%)
Very difficult	39	(11.7%)

Table 49

Are [you/R] considering enrolling in Cal-MediConnect at a later date?

	Opt Out (*n*=301)	
Yes	41	(13.6%)
No	260	(86.4%)

Table 50

Since [you/R] switched to [CMC health plan name] has the plan done anything to make it safer or easier for [you/R] to live in [your/his/her] own home?

	Total (*n*=205)	
Yes	52	(25.4%)
No	153	(74.6%)

Table 51

Equipment or Modifications Provided by Plan for Safer or Easier Living at Home (n=101)

Description	n	%
General statements about increase in services	14	13.9
In-home check-ins	13	12.9
Mobility aids (i.e., walker, cane, wheelchair, scooter)	12	11.9
Home equipment (i.e., shower seat, commode, bath chair, mats)	11	10.9
Clinical support by medical provider (i.e., nurse, doctor, counselor)	10	9.9
Comfort or peace of mind in safer home	10	9.9
Home modifications (i.e., grab bars, rails, ramp, shower)	9	8.9

General information and resources	9	8.9
Assistance with daily living (i.e., chores, cleaning, cooking, shopping, bathing, getting dressed)	7	6.9
Medication management and support	6	5.9
Transportation services	6	5.9
Telecare or alert systems (i.e., life alert, surveillance camera)	3	3
Alternative housing assistance	2	2
Unrelated	2	2
Home appliances (i.e., washers, dryers, refrigerator)	1	1
Home heating or cooling systems	0	0
Electrical or gas safety equipment	0	0

Table 52

[Do you/Does R] usually get all the help [you need/R needs] with personal care and routine needs?

	CMC (*n*=267)		Opt Out (*n*=320)		NON-CCI (*n*=309)		Chi-square test	df	*p*
I could use more help	91	(34.1%)	129	(40.3%)	144	(46.6%)	12.428	6	0.053
I get all the help I need	152	(56.9%)	169	(52.8%)	142	(46.0%)			
I get no help at all	23	(8.6%)	18	(5.6%)	21	(6.8%)			
I don't need help	1	(0.4%)	4	(1.3%)	2	(0.6%)			

Table 53

[Among IHSS Recipients]: [Do you/Does R] usually get all the help [you need/R needs] with personal care and routine needs?

	CMC (*n*=141)		Opt Out (*n*=198)		NON-CCI (*n*=157)		Chi-square test	df	*p*
I could use more help	45	(31.9%)	72	(36.4%)	70	(44.6%)	8.969	6	0.175
I get all the help I need	94	(66.7%)	120	(60.6%)	86	(54.8%)			
I get no help at all	1	(0.7%)	5	(2.5%)	1	(0.6%)			
I don't need help	1	(0.7%)	1	(0.5%)	0	(0.0%)			

Table 54

[Among LTSS Users] Has anyone from CCI health plan ever talked to [you/R] about [your/R's] LTSS?

	CMC (*n*=119)		Opt Out (*n*=127)		Chi-square test	df	*p*
Yes	42	(35.3%)	45	(35.4%)	0.001	1	0.982
No	77	(64.7%)	82	(64.6%)			

Table 55

Have there been any changes in [your/R's] long-term services as a result of the change to CCI health plan?

	CMC (*n*=115)		Opt Out (*n*=130)		Chi-square test	df	*p*
Yes	9	(7.8%)	9	(6.9%)	0.073	1	0.787
No	106	(92.2%)	121	(93.1%)			

Table 56

Do you have a care coordinator?

	CMC (*n*=701)		Opt Out (*n*=639)		NON-CCI (*n*=717)		Chi-square test	df	*p*
Yes	248	(35.4%)	126	(19.7%)	126	(17.6%)	73.444	4	<0.001
No	437	(62.3%)	497	(77.8%)	578	(80.6%)			
I have a care coordinator, but I haven't been in touch with him/her in the past 6 months	16	(2.3%)	16	(2.5%)	13	(1.8%)			

Table 57

Overall, are [you/R] currently satisfied or dissatisfied with [your/R's] health insurance benefits?

	CMC care coordinator not main (*n*=580)		CMC care coordinator (*n*=136)		Chi-square test	df	*p*
Very dissatisfied	37	(6.4%)	3	(2.2%)	21.491	3	<0.001
Somewhat dissatisfied	32	(5.5%)	4	(2.9%)			
Somewhat satisfied	219	(37.8%)	31	(22.8%)			
Very satisfied	292	(50.3%)	98	(72.1%)			

Table 58

Did you know that Cal MediConnect plans will provide their members with up to 30 one way rides per year to the doctor or other health related appointments (picking up prescriptions/getting lab tests)? (only asked of CCI Rs)

	CMC care coordinator not main (*n*=477)		CMC care coordinator (*n*=137)		Chi-square test	df	*p*
Yes	194	(40.7%)	91	(66.4%)	32.707	2	<0.001
Yes, but I thought it was a different number of rides	15	(3.1%)	7	(5.1%)			
No, I was not aware I could get rides through the Cal MediConnect plan	268	(56.2%)	39	(28.5%)			

Table 59

Because of switching to CCI, did you experienced any delays or problem getting any of the care, services or supplies you need?

	CMC care coordinator not main (*n*=471)		CMC care coordinator (*n*=137)		Chi-square test	df	*p*
Yes	94	(20.0%)	20	(14.6%)	2.001	1	0.157
No	377	(80.0%)	117	(85.4%)			

Table 60

[Has that/have those] problem(s) been resolved or [is it/are they] still ongoing?

	CMC care coordinator not main (*n*=89)		CMC care coordinator (*n*=19)		Chi-square test	df	*p*
All problems resolved	26	(29.2%)	12	(63.2%)	7.951	2	0.019
Some problems resolved but not all	21	(23.6%)	2	(10.5%)			
None of the problems are resolved	42	(47.2%)	5	(26.3%)			

Table 61

Do [you/R] use mental health care?

	CMC care coordinator not main (*n*=602)		CMC care coordinator (*n*=138)		Chi-square test	df	*p*
Yes	120	(19.9%)	45	(32.6%)	10.410	1	0.001
No	482	(80.1%)	93	(67.4%)			

Table 62

(CMC only) Were you aware that [CMC plan name] can provide you with a care coordinator if you needed one?

	CMC (*n*=605)	
Yes	361	(48.5%)
No	244	(32.8%)