



PERRYUNDEM
RESEARCH/COMMUNICATION

Experiences with Financial Alignment Initiative Demonstration Projects in Three States

Feedback from Enrollees in California, Massachusetts, and Ohio

May 2015

Content

Introduction	3
Methodology	5
Overview of Findings	6
Detailed Findings	10
I. Overall Opinions	10
II. Understanding of the Demonstration	11
III. Provider Awareness	12
IV. Enrollment.....	13
V. Communications	16
VI. Access to Providers and Services	17
VII. Care Coordination	22
VIII. Costs.....	25
Conclusion	27

Introduction

Beneficiaries, providers, advocates, and policymakers have all raised concerns about the extent to which Medicare and Medicaid could work better together for beneficiaries enrolled in both programs. In order to address this challenge, two entities within the Centers for Medicare & Medicaid Services (CMS) – the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation (CMMI) -- created the Financial Alignment Initiative Demonstration. This three-year demonstration project is designed to allow states to test models of integrated care that have the potential to improve quality and reduce costs for dually eligible beneficiaries.

CMS is testing two financing and care management models under this initiative:

- **Capitated Model:** A state, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended Medicare-Medicaid payment to provide and coordinate all Medicare and Medicaid services. The rate includes savings to both Medicare and Medicaid.
- **Managed Fee-for-Service Model:** A state and CMS enter into an agreement by which the state would be eligible for bonuses based on performance and savings.ⁱ

CMS intends to enroll up to 2 million of the 10.7 million dually eligible beneficiaries into this demonstration program.ⁱⁱ As of April 2015, twelve states are participating in the Financial Alignment Initiative Demonstration program.ⁱ Through the demonstration, each state has developed unique program mechanisms to improve quality and reduce costs of care. Each program targets different subgroups of dually eligible beneficiaries, offers varying benefits and care coordination services, and uses differing payment frameworks. Despite these differences, the underpinning of each demonstration program is the emphasis to improve care coordination for dually eligible beneficiaries. Each state requires that every enrollee have a health assessment, an individualized care plan, and an interdisciplinary care team. These care coordination mechanisms have the potential to improve care and reduce costs for this high needs population.

However, these demonstration programs are new and still developing. In addition, beneficiaries have voiced concerns regarding the enrollment process, communication to potential enrollees, and plans' ability to meet the needs of the complex and vulnerable population. Understanding beneficiaries' early perspectives and experiences regarding the program is valuable information that can help inform future development of these demonstrations.

The Medicaid and CHIP Payment and Access Commission (MACPAC) is interested in better understanding the early experiences of individuals enrolled in these demonstration projects. Specifically, MACPAC is interested in examining the beneficiaries' perspectives regarding the demonstration's enrollment process, communication with beneficiaries regarding this model of care, experiences and understanding of care coordination services under the demonstration, and access to services under the demonstration. MACPAC contracted PerryUndem Research/Communication to conduct seven focus groups with

beneficiaries enrolled in a capitated model of the Financial Alignment Initiative Demonstration program. These focus groups occurred across three states (California, Ohio, and Massachusetts) over a nine-month period. This report focuses on the findings of these seven focus groups and illustrates the challenges and benefits beneficiaries have experienced as these programs are implemented throughout the country.

Methodology

Seven focus groups were conducted between June 2014 and February 2015 with 55 dually eligible beneficiaries who were enrolled in the California, Massachusetts, or Ohio Financial Alignment Initiative Demonstration projects. (See Table 1 for details.)

The seven focus groups were conducted in six cities: Boston, MA, Worcester, MA, Cleveland, OH, Cincinnati, OH, San Diego, CA and San Mateo, CA. The selection of cities was based on enrollment start date, number of beneficiaries enrolled in the program, and ability to recruit to participants to a focus group. Six of these cities (Boston, Worcester, Cleveland, Cincinnati, and San Mateo) had one focus group conducted. San Diego had two focus groups conducted, one in English and one in Spanish.

The focus group participants were recruited from within the selected city and the surrounding areas. The 55 participants ranged in age from 33 to 89 years old and included those with significant disabilities. The participants represent a mix of gender, race, and health plan membership. Participants were nominally compensated for their participation in the focus groups, and provided transportation, if needed.

In addition, the participants represent a mix of individuals who were passively enrolled into the demonstration, as well as those who voluntarily enrolled into the demonstration. Most of the participants had received services through the demonstration for at least six months prior to the focus group.

The Boston, Worcester, Cleveland, Cincinnati, and San Diego participants were recruited through community-based organizations including, Centers for Independent Living and senior centers. In San Mateo, the Health Plan of San Mateo helped to identify eligible participants for the focus groups. Participants were initially screened by the recruiting organization and then by PerryUndem.

The following findings are generalizations about each program based on the experiences and opinions of the 55 individuals who participated in the focus group discussions.

These focus groups were intended to air beneficiaries' experiences and themes, and thus enhance our understanding of the Financial Alignment Initiative Demonstration. They were not intended to offer definitive explanations or evaluate the programs. In addition, given this relatively small sample size, the findings in this report not necessarily representative of the entire population enrolled in the Financial Alignment Initiative Demonstration.

Table 1: Focus Group Dates, Locations and Size

<i>Date</i>	<i>City</i>	<i>Participants</i>
June 24, 2014	<i>Boston, MA</i>	<i>8</i>
	<i>Worcester, MA</i>	<i>9</i>
January 28, 2015	<i>Cleveland, OH</i>	<i>10</i>
January 29, 2015	<i>Cincinnati, OH</i>	<i>10</i>
February 3, 2015	<i>San Diego, CA</i>	<i>12</i>
February 4, 2015	<i>San Mateo, CA</i>	<i>6</i>
Total		<i>55</i>

Overview of Findings

Across the focus group sites, experiences with the Financial Alignment Initiative Demonstration program were mixed. Some focus group participants were noticing greater care coordination among their providers, receiving assistance and guidance from their care coordinators, and accessing new services like expanded dental and transportation services. However, other focus group participants still have many questions about the program and have yet to see a difference in their care. It is important to keep in mind that when we conducted the focus groups, these programs were still relatively new. Most of the focus group participants had been enrolled in and receiving services through the demonstration program for approximately six months, and the programs were still evolving during this time. Following are some of the key takeaways from the focus groups.

- ***The Demonstration's Intent Appealed to Participants.*** During each focus group, the moderator explained the purpose, intent and benefits offered under the Financial Alignment Initiative Demonstration. When the focus group participants received a clear definition of the program and understood its purpose, they reported that not only did they agree with the intent of the demonstration, they also wanted this approach to care. Across the focus group sites, participants reported that having separate Medicare and Medicaid coverage resulted in fragmentation of services, confusion in navigating both programs and felt they were solely responsible for managing their complicated health care needs. Most of participants said that they wanted more integration between Medicaid and Medicare, more care coordination, someone to help them access care and solve problems, and wanted access to additional services such as, dental coverage, transportation, and behavioral health services. These requests are all prominent features of the demonstration. In addition, those already utilizing long-term care services are particularly interested in this model of care – most believe they will receive better care and more support to remain independent as long as possible.
- ***Participants and Their Providers Were Still Learning About the Demonstration.*** However, prior to receiving an explanation of the demonstration during the focus group, many of the participants did not have a clear understanding of the demonstration program. When asked, they could not explain the purposes of the program, name the program, or identify all of the programs' expanded services or benefits. Spanish-speaking participants have the largest knowledge gaps. Many focus group participants also said their providers (i.e., primary care providers, specialists, dentists, and pharmacists) were not well-informed about the program. Many said their providers did not recognize the name of the program and were unclear whether they participated in the demonstration program. Others mistakenly charged copays for services that were supposed to be free. At the time the focus groups were conducted, it was clear that both providers and beneficiaries were still learning about the features of the demonstration.

- ***Program Materials Were Not Clear.*** Part of the awareness problem seems to have stemmed from unclear and confusing program materials. Participants noted that the materials they received prior to enrollment and after enrollment were not clear or written in simple language they could easily understand. Others feel there was too much paperwork, which they found overwhelming. Spanish-speaking participants said they received program materials in Spanish, which they appreciated. They also said that interpretation and translation services were available through the program and that these services worked well. They did not feel there is a language barrier. However, it was unclear whether these participants read the program materials or fully understood the materials, as the Spanish-speaking focus group participants tend to be most confused about this model of care and about the purposes of the demonstration program.
- ***Enrollment Went Smoothly for Many.*** Each focus group site contained a mix of individuals who either voluntarily enrolled or were passively enrolled into the program. For focus group participants who voluntarily enrolled, the enrollment process (which included selecting a plan and submitting necessary paperwork) went smoothly for most. The process was easiest when focus group participants had help from someone, such as a social worker or case manager, to aid him or her through the enrollment process. For these individuals who voluntarily enrolled, keeping their doctors was the most important factor in picking a health plan and in choosing to participate in the demonstration project. Those who were passively enrolled had mixed experiences. Many were content with the process and found it convenient. However, others were not aware their coverage had changed and this caused problems when they went to access care or pick up a prescription. A few were enrolled in plans they did not want or were unhappy their prior coverage was dropped.
- ***The Transition Into the Program Was a Challenge for Some.*** During the first weeks and months in the new program, some focus group participants suffered lapses and delays in care, could not fill prescriptions, were mistakenly charged copays, had negative experiences with transportation services, and had personal care attendants who were not paid. Often it was the focus group participants who were passively enrolled into the program – and were not aware of the changes to their coverage – who faced the most problems. Others tried to make appointments with their primary care providers or dentists shortly after they enrolled only to be told they did not accept their coverage, which delayed care for a few focus group participants.
- ***Most Were Able to Keep Their Providers.*** When participants enrolled into the demonstration program, most said they were able to keep their same providers. Some took an active role in contacting their providers to confirm that they participated in the demonstration and would accept their new insurance. The ability to keep their providers was an important factor when deciding to participate in the demonstration program and when picking a health plan. However, a few said they

had to find new providers, in particular specialists, after enrolling in the demonstration program.

- ***Participants Value the Expanded or New Services Offered.*** All focus group participants said they valued the coverage of the expanded and new services offered under the demonstration. In particular, they appreciated access to new dental, vision, non-medical transportation, and behavioral health services. Those focus group participants who have used these expanded or new services were often very satisfied with the care they received. However, a few participants noted that due to the expanded coverage, in particular dental coverage, there were also access issues. Some participants reported long wait times for services and difficulty in finding a dentist willing to see them.
- ***Costs Have Stayed the Same or Gone Down.*** Focus group participant reported that their costs have stayed the same or have gone down after enrolling in the demonstration. This was a positive outcome for focus group participants, who overall found the program to be affordable. While some were mistakenly charged copays for prescriptions and services early on, most of those problems have been resolved. Most said their doctor visits, dental and vision care, hospitalizations, and long-term services and supports (LTSS) needs such as home modifications have all been covered by their new plans. However, a few focus group participants said that costs at pharmacies and for some durable medical equipment have increased.
- ***There Were Challenges with the Care Coordinator Role.*** A number of focus group participants did not yet have a care coordinator and some have only had minimal contact with their care coordinator. Not having direct or consistent contact with a coordinator created challenges for many participants, as participants who had connected and established a relationship with a care seemed to be have better experiences in the program. The care coordinator provides many important services in this program – from participating in an initial assessment and developing a care plan to troubleshooting for beneficiaries and helping them access new services. Importantly, the care coordinator plays a vital educational role, explaining the program and the new services available to beneficiaries. A few of the focus group participants who had not yet connected with a care coordinator believed that the program may be overloaded and that there are not enough care coordinators to go around.
- ***Some Were Experiencing a “Team-Based” Approach to Care but Others Were Not.*** Some focus group participants said they were starting to see a change in how their providers were communicating and believe they were sharing information more so than before. A few participants explained that when there was a conflict, such as a possible negative interaction between prescription medications, the providers can work with one another to figure out a solution. But other focus group participants were not experiencing a team-based approach yet

among their providers. They felt the burden of communication still primarily rests with the patient, not their providers. Some did not even know that a team-based approach to care delivery was a part of the demonstration program, or that they should be looking for this type of coordination.

- *Participants Believed the Model Holds Promise.* While some focus group participants in this study already seemed to be experiencing the benefits of more care coordination and additional services, others were still struggling to understand and benefit from the program. Nevertheless, they agreed that this new approach to care has the potential to improve their care and overall health. Almost all said they wanted more coordination among their providers, more help navigating the system and resolving problems, and access to additional services, such as expanded dental and transportation services. As this model matures and as beneficiaries and providers gain more experience and knowledge regarding the demonstration, it is likely that a number of the problems and the confusion that emerged in the focus groups can diminish.

Detailed findings about these and other insights can be found on the following pages.

Detailed Findings

I. Overall Satisfaction

While the demonstration programs are still new in the three states visited for this project, the individuals enrolled in the demonstration programs were able to provide helpful feedback regarding their experiences in the Financial Alignment Initiative Demonstration. Overall, satisfaction with the demonstration program varies by state, within a state, and by focus group participant. There were some focus group sites where the majority of the focus group participants were happy with the program. These individuals have noticed positive changes in their care, were seeing more coordination, and were accessing new services. However, there were other focus group sites where the first few months of the demonstration program were challenging, causing overall frustration with the program. These participants had many questions about their care, had already faced barriers in accessing care, and were not experiencing the care coordination components, such as a designated care coordinator, a team-based approach, or comprehensive health assessments, which mark the foundation of the demonstration program.

In Massachusetts, Worcester focus group participants reported greater satisfaction with One Care (the Massachusetts demonstration program) than Boston focus group participants. Those in Worcester felt their health and health care had improved since enrolling in the demonstration, while Boston participants had not noticed improvements in their health or health care delivery. For example, Worcester enrollees reported a high degree of care coordination and use of new or expanded services. Conversely, those in Boston did not seem to have much care coordination and were overall less informed about how to navigate this model of care and were unaware of all available services. The Boston participants believed the health plans were not prepared for the demand and, as a result, were having difficulty serving its enrollees. The biggest challenge for the Boston focus group participants was connecting with their care coordinator. Many had not yet spoken to a care coordinator or had only limited contact with a coordinator since enrolling in the program.

In Ohio, the focus group participants in both sites (Cleveland and Cincinnati) expressed frustration around implementation problems during the MyCare Ohio (the Ohio demonstration program) rollout. In Cincinnati, focus group participants reported experiencing continued issues with their care and have questions about the care coordinator role (similar to Boston). For example, a man with a traumatic brain injury in Cincinnati said he learned in January 2015 that his doctor is no longer in his plan's network. He was not sure how to find a new primary care physician or who to ask for more information and help to find a new physician. As a result, he has been going without care. Another Cincinnati man was struggling to find an in-home caregiver to replace the one he lost after he enrolled in the program. At the time of the focus group, he had been relying on family members to assist him in meeting his care needs. These frustrations left the Cincinnati group more frustrated with the program than those in Cleveland. Cleveland focus group participants seemed to have a more established relationship with their care

coordinators and have more clarity around how to use this model of care. However, some of the Cleveland focus group participants were still experiencing some access issues and confusion regarding how the demonstration worked and available services.

In California, the focus group participants were overall satisfied with Cal MediConnect (the California demonstration program). Participants in both San Diego and San Mateo value the new expanded coverage of dental, vision, and non-medical transportation services. In addition, California participants noted they preferred this new model of care delivery, in which their Medicare and Medicaid is provided through one coordinated program, as opposed to their previous coverage through separate Medicare and Medicaid programs. They noted it was easier to navigate one program instead of two or three separate programs. As a result, some participants reported that they noticed improvements in their health and care delivery. However, in both San Diego and San Mateo, there was still confusion with regard to how Cal MediConnect works and the services available to them. This was especially true among the Spanish-speaking focus group participants.

II. Understanding of the Demonstration

Most participants across all focus group sites did not have a comprehensive understanding of the Financial Alignment Initiative Demonstration program. Many were unclear how this model of care differed from what they had experienced in the past. In addition, there was also ambiguity regarding the specific components of the model. Only a handful of participants were able to give an accurate description of the program. These participants tended to be those who read the program materials or those who had talked to an informed individual about the program. Most others, however, lacked basic information about how the program works and the program's purpose. Many were also unaware they were eligible to receive new services.

Across all the sites, Worcester participants were the most likely to have a clear understanding of the program. This was likely due to the fact that most of the Worcester focus group participants reported that someone, usually their care coordinator, explained the program's purpose and benefits to them from the outset, which was critical to their understanding of the program. In Boston, most of the participants noted that no one described the program to them prior to or after enrolling. Their main sources of information were letters they received in the mail, which were unclear. In addition, many of the Boston focus group participants had yet to connect with a care coordinator, which may explain why there was less understanding about this model of care.

In Ohio, a majority of focus group participants struggled to provide a description of MyCare Ohio beyond the understanding that Medicaid and Medicare were "combined." Most focus group participants were unaware of the services covered under the demonstration, who to turn to if they had a question regarding their care, or how to become more engaged in their care delivery. However, there were a few individuals in each site who were more knowledgeable than others. These informed individuals were those who attended informational meetings sponsored by community based organizations and senior residential buildings to help

educate eligible individuals about MyCare Ohio. Those less informed appeared to be more socially isolated, disconnected from services, or have cognitive disabilities.

In California, a few participants had a clear understanding of Cal MediConnect and how it is intended to work. However, like the participants in Boston, Cleveland, and Cincinnati, most do not understand the program. Again, the informed participants tend to be the individuals who made a concerted effort to learn about the demonstration. The Spanish-speaking focus group participants were less informed about the program and how it differed from their previous Medicare and Medicaid plans than other California focus group participants. Also, many of the focus group participants in the California sites did not know their care coordinator and how the care coordinators can help them. This, again, may account for why many enrollees in the California sites still have questions about their coverage.

However, most focus group participants believe in the intent of the demonstration, which was an important insight gained during the focus groups. When the demonstration program's purpose, benefits, and care coordination elements were explained to the focus group participants, across every site there was a resounding positive reaction. Focus group participants reported that they wanted more coordination, needed someone to help them manage their care, and valued having coverage to more services.

III. Provider Awareness

In some of the sites, focus group participants said their providers had little or no knowledge of the demonstration program. The focus group participants found this disconcerting, as they also had limited knowledge of the program. Most often it was their primary care providers and pharmacists who seemed unaware of the program, but some said their specialists were also unaware. This caused problems for some of the focus group participants, including delayed appointments, incorrect financial charges, and requiring participants to find a new provider.

This issue emerged clearly in Massachusetts, particularly in Boston. Some of the participants told stories of arriving for appointments only to be told by front office staff that they did not accept the coverage. Others had their doctors ask them, "What is One Care?" Many found it alarming to educate their providers on One Care, as these individuals assumed their providers would know more about the program than they did.

In Ohio, focus group participants said the majority of their doctors were familiar with MyCare Ohio. However, participants in both Cleveland and Cincinnati said that pharmacists were not familiar with the program. Many individuals reported that their pharmacists had not seen a MyCare Ohio health plan card, did not know how to enter new MyCare Ohio health plan information into their system, or how to bill MyCare Ohio for the participant's prescriptions. As a result, some of the Ohio focus group participants were told their medications were not covered or that they had to pay a copay. It has been difficult for some individuals to solve this problem, since many did not have a care coordinator.

However, lack of awareness among providers did not seem to be a problem in the California sites. According to the focus group participants, their providers knew about Cal MediConnect. Many also noted that their providers were helpful in educating them about the program.

IV. Enrollment

Enrollment in Massachusetts, Ohio, and San Diego began with a voluntary enrollment period. During this voluntary period beneficiaries could opt out of the demonstration, or enroll in a managed care plan that would provide their Medicare and Medicaid services. This voluntary enrollment period was then followed by a passive enrollment period. During the passive enrollment period, beneficiaries that did not voluntarily enroll (or had not already chosen to opt-out of the demonstration) were automatically assigned to a managed care plan to provide their Medicare and Medicaid services. (In San Mateo, beneficiaries were automatically enrolled in the demonstration without the initial voluntary enrollment period).

For most of those who voluntarily enrolled in the program and actively chose a health plan, the actual enrollment process went relatively smoothly. Enrollees who voluntarily enrolled were able to choose a health plan and submit their request to the state relatively easily. Some of those who voluntarily enrolled said they had help from social workers or case managers who aided them through the enrollment process by helping them choose a plan, ensuring paperwork was filled out correctly, and submitting the necessary forms. Many of these enrollees chose plans based on individual research. They noted that keeping their current provider was a key factor when choosing a plan. These individuals reported that they were generally happy with their choice in health plan because they were able to keep their doctor. Others based their choice on their prior experience with the plan. However, some felt there was too much paperwork in the enrollment process.

Of those that were passively enrolled, many noted that their engagement in the enrollment process was limited. However, the participants' opinions regarding the passive enrollment process varied. Some participants did not mind the automatic process, but others did not like that they had no choice in participation, felt forced into a plan, and were uninformed or misinformed about the opt-out process. In some cases, participants said they were not informed about the new plan assignment until after their enrollment in the plan. Individuals who were passively enrolled seemed to have faced some of the biggest challenges in transitioning into their new plan. They tended to know less about the plan and its potential benefits to them.

Finally, neither the voluntary or passive enrollment process seemed to effectively educate the participants regarding upcoming changes to their care delivery. Most participants had as many questions about their coverage after enrollment as they did before they enrolled in the program. Those individuals passively enrolled seemed to know the least and were less likely to have sought out information about the demonstration or the plan.

In Massachusetts, most participants in the focus groups appeared to have been passively enrolled into One Care. A few enrollees opted-out of the demonstration after first receiving letters in the mail about the program, but later actively chose to opt back into the program. One reason some individuals initially opted out was because the information they received about the program did not effectively communicate the benefits of the program. As one Boston man describes, "The letter I got was pretty cryptic." He later decided to enroll when he heard a radio interview about the program and learned about the specific benefits – he then decided that the program was, in fact, a good fit for him. Most enrollees in both Massachusetts sites seemed fine with the fact that they were passively enrolled into the program. As mentioned, Worcester enrollees were already experiencing a number of benefits from One Care and were happy with the switch.

In Ohio, the individuals in the focus groups included a mix of people who voluntarily enrolled or were passively enrolled in the program. Although participants provided mixed reviews regarding both the active and passive enrollment processes, there was a sense of overall frustration with the enrollment process. Typically, the frustration stemmed from lack of information about the program. Many who voluntarily enrolled had questions about the program prior to enrolling. The process of getting these questions answered during the enrollment period was challenging for some. Participants reported long waits on hold when calling the health plan or state, and others noted not receiving any answers to their questions. Passive enrollment was easier for some due to the nature of that specific enrollment method. These participants said there was little to nothing they needed to do to enroll. However, some who were passively enrolled did encounter problems, such as not being contacted about their enrollment in the program until after enrollment was completed. Others felt "forced" into the program and wished that the program had reached out to them earlier to explain the new coverage so that they could have been prepared and anticipated challenges.

Focus group participants in California also have mixed experiences with enrollment. As in Ohio, those who passively enrolled had little to no difficulty with the procedural aspects of enrollment. However, in San Mateo, enrollees were confused with the letters they received about the enrollment process and timeline. Some did not understand their choice to opt out of the demonstration. While others mistakenly believed they would lose all their established benefits under their previous Medi-Cal and Medicare coverage if they did not enroll in the demonstration program. As a result, they did not feel they had a choice regarding enrollment.

In San Diego, those who passively enrolled encountered some difficulties just as in the other sites. For example, one woman did not learn about her enrollment in Cal MediConnect until she visited her doctor for a scheduled visit and learned that her doctor was no longer covered. So, despite the ease of procedural aspects of a passive enrollment process, focus group participants felt that improvements could be made to reach out to them beforehand to better explain the changes to their coverage.

V. Communication with Beneficiaries

Participants across all focus group sites gave negative feedback on the materials they received from the state about the demonstration program and from their health plan explaining their new coverage. Usually, the information came in the form of a letter telling them about the demonstration and a booklet outlining their plan's coverage. Most participants found these letters and booklets to be dense and confusing. They said the information they received regarding the program was written using technical language or at a very high level, which was difficult to understand. A few of the participants in the focus groups had cognitive disabilities, which made understanding these materials even more difficult.

The Spanish-speaking focus group participants in California reported that they received information regarding the program written in Spanish. Still, there were times when they receive materials or letters in English. When this happened, the Spanish-speaking participants said translators were generally available when needed.

In-person communication seemed to be the best form of communications for the focus group participants. Participants that were most informed were more likely to have attended seminars explaining the demonstration or more likely to have had one-on-one meetings with social workers, care coordinators, staff at senior housing centers, or individuals from community-based organizations. A few California participants said their doctors were also helpful in explaining their new coverage.

There was also agreement among the focus group participants that they received too much paperwork from the state and the health plan. In Ohio, this was a particular complaint. They found all the information they received overwhelming. Some noted it was difficult to determine which information was important and what was "junk" mail. Many noted that it would have been beneficial if the most important information were conveyed simply, with fewer words and on one piece of paper.

Participants across all focus group sites were remarkably consistent on this issue. They felt the materials they received about the demonstration and their health plans were not user-friendly. However, they were also equally consistent in admitting that they did not always read these materials. Many acknowledged they could have learned more about their coverage if they applied themselves and tried to read the materials.

VI. Access to Providers and Services

Across the focus group sites, most participants said they were getting the care they needed and accessing the new and expanded services that initially piqued their interest in the program. However, some faced issues accessing care when the programs were initially rolled out and some still face challenges in finding providers that accept their new coverage.

A. Primary Care Providers

The majority of focus group participants were able to keep their primary care providers after enrolling in the demonstration program. Keeping their primary care provider, with whom they have developed a rapport over several years, was important to the participants. In fact, many said they would not have enrolled in the program if they had to change providers. Some said they called their doctor or health plan to confirm their doctor's participation in the plan before enrolling.

However, it should be noted that participating health plans are required to allow enrollees to continue to see their established providers and complete any ongoing courses of treatment during the beginning the demonstration. This is regardless of the provider's participation in the demonstration and the scope of coverage of the plan. However, the length of time an enrollee can continue to see a provider not participating in the demonstration or receive services not covered by the demonstration can vary by state and by health need. Some participants reported that they would be upset and rethink their participation in the demonstration if they were no longer able to see their providers.

There were a few exceptions in each state where a provider was not covered or was initially covered and then stopped participating in the demonstration at the start of 2015. In California, a few participants who were not able to keep their provider or did not previously have a doctor were assigned a primary care provider. There were a few individuals in the Ohio focus groups who were still looking to find a new primary care provider because their previous primary care provider no longer accepted their MyCare Ohio plan.

B. Specialists

In addition, most of the participants were able to keep their specialty providers. However, a few said they had to find new specialists after enrolling in the demonstration program. Some in Boston found that their mental health providers and other specialists did not accept One Care. Enrollees feel they had to make trade-offs between receiving more care coordination and extra services and keeping their specialists.

Some also faced challenges finding a new specialty provider who would accept their new coverage. One woman in San Diego recalled being told by two dermatologists that they accepted her Cal MediConnect health plan. However, when she arrived for her appointments she was told her coverage was not accepted and she was not able to receive care. Eventually she went to an urgent care center to have her skin issue addressed.

C. Behavioral and Mental Health Services

Generally, the focus group participants seeking behavioral and mental health services said they were available through their new health plans. In addition, these participants were overall satisfied with their mental and behavioral health care.

Massachusetts was one state that expanded coverage of behavioral health services for individuals enrolled in the demonstration. Focus group participants value this expanded coverage. However, even with this new coverage there are still access issues. As noted

above, some individuals in the Massachusetts focus groups have had to find new mental health providers, as their previous providers do not participate in the demonstration.

Conversely, California focus group participants receiving mental health services noted that they were able to maintain their established mental health providers. Many noted that having this continuity with providers was important to them and were relieved to find that they would not lose access to things like day treatment programs when enrolling in Cal MediConnect. However, it is likely that California enrollees did not experience many changes to their mental health care because behavioral health services are not included in the capitated payment made to the participating health plans. These services have continued to be financed and administered by county agencies under the provisions of the 1915(b) waiver and the state's Medicaid plan.

D. Dental Services

Expanded access to dental care (where offered as part of the demonstration program or through the participating plan) was one of the features that the focus group participants were most excited about. The participants highly valued dental care because under their previous Medicaid and Medicare plans this care had not been covered or only limited services were available. However, participants felt that expanded coverage of dental services has also created long wait times for services and difficulty in finding a dentist willing see them.

In Massachusetts, focus group participants said it has been difficult to find a dentist who accepts One Care plans. Some said they contacted dentists listed as part of the One Care network only to be told by the dentist that they do not participate or that they are not sure if they participate. For this reason, many have delayed dental care as they continue to look for dentists who accept their new coverage.

Similarly, in Ohio, many of the focus group participants faced barriers accessing dental services. In both Ohio sites, participants reported problems finding dentists who accepted their new coverage. Some said a dentist had told them that they accepted their MyCare Ohio plan only to be told their coverage is not accepted when they arrive for their appointment. Others who have been able to find a dentist said they have to wait four months to get an appointment.

In San Diego, those who used dental services were overall satisfied with the care they received. They were happy to be able to access the dental care they were putting off for years, which included getting new dentures and actually having their teeth "fixed" instead of just having teeth extracted. As one woman describes, "It makes me happy... it makes me feel really good because I have this big wide smile and I want people to see teeth and not the spaces."

Despite these positive experiences with expanded dental services, some California focus group participants encountered difficulties accessing dental services in a timely manner.

Some have been told they were not an emergency case and were referred to a dental college to get care. Others had been told they had to wait up to nine weeks to get an x-ray.

E. Vision Services

Vision services seemed to be working well for many of the focus group participants. Many were pleased to have the expanded benefits that enabled them to get glasses and eye exams at no or low costs. In Massachusetts, many were drawn to the program when they learned that vision benefits would be expanded to cover contact lenses. While none had attempted to obtain contacts yet, participants liked having this as an available option.

In Ohio, participants were excited to obtain eyeglasses and exams with little to no out of pocket spending. However, a few participants expressed disappointment with the quality of glasses that are covered. One man explained that the frames of his glasses started to turn green within six months and he developed a rash from the oxidation of the metal.

In California, most participants said they were pleased with the optometrist they have seen since enrolling in Cal MediConnect. However, some faced issues accessing providers and receiving quality vision services. One individual said he requires special lenses for extreme myopia and that his lenses are not covered by his Cal MediConnect plan. In addition, a Spanish-speaking woman recalled seeing two different ophthalmologists and received two different diagnoses for her vision. She was discouraged by the conflicting results and did not want to return to the doctor for a follow-up despite having a lot of pain in her eye.

F. Transportation Services

Transportation services were another benefit of the program that the focus group participants were eager to use. This was also a service many participants used and had strong feelings about. Those who used transportation services were pleased that both medical and non-medical rides are covered through the demonstration and participating health plan. But across all three states there were individuals who were not aware of transportation services, particularly for non-medical purposes, but wanted to learn more about how to access this benefit. There were also problems with the delivery of transportation services in some sites, which was a sore point with participants as they depend on these services.

Participants in the Boston focus group said they were having problems with transportation services. Many said they experienced delayed pick-ups, long waits, discourteous drivers, and, in one case, a request for a female driver was denied. Some feel that transportation services under the previous MassHealth system were better and more reliable. Participants in the Worcester focus group, on the other hand, said that transportation services had improved under One Care. Additionally, they valued that they could now use transportation services for approved non-medical appointments such as school, work, volunteer activities, and even bingo. They felt these expanded transportation services help contribute to keeping them active and staying healthy.

In Ohio, transportation services received mixed reviews. Although, participants were happy to be able to use transportation for non-medical services, there were problems in accessing transportation services. Participants noted that their transportation services frequently were late and sometimes did not show up at all. Others said they now have limits on the number of trips they receive. For these participants before enrolling in MyCare Ohio, they did not have to keep track of the number of trips they used.

In California, participants were also pleased with the ability to use non-medical transportation services. In San Diego, participants said reliability and customer service had improved since the start of the demonstration. However, one woman who was using transportation services in San Mateo said that service has not improved, as rides continue to arrive late or too early.

G. Long-Term Services and Supports & In-Home Support Services

Across the focus group sites, there were few participants that used long-term services and supports (LTSS). Of these few participants using LTSS, most were satisfied with many of the LTSS benefits they were receiving, which often included home delivered meals and support from personal care attendants. However, some focus group participants, particularly those in Ohio, experienced gaps in care during the transition into their new health plan. Others feel accessing LTSS and home modifications have been arduous. Finally, a number of participants in each site are unaware of the LTSS available (however, most often these individuals are those who do not need LTSS care at this time).

Focus group participants in Worcester gave positive feedback about LTSS benefits. Several had received home modifications such as installing shower bars that have allowed them to feel more comfortable and safe in their own homes. A few Worcester participants were also receiving care from personal care attendants. Before enrolling in OneCare one woman explained that personal care attendants were not covered under her health plan. She was thankful that through this new benefit she has someone to come into her home and assist her with things around the house that she was unable to do on her own, such as reaching items that are out of reach. She explained that working with a personal care attendant makes her feel taken care of.

In Ohio, one of the most disruptive issues was the lack of payment to in-home caregivers. These in-home caregivers work independently and were chosen directly by focus group participants rather than found and directly paid through an agency. The two individuals – one in Cleveland and the other in Cincinnati – rely on in-home care to perform their daily activities of living. However, after enrolling into the demonstration their in-home caregivers stopped receiving payment. These two focus group participants did not want to lose their trusted caregivers. As a result, one individual actually paid out of pocket to keep his provider, but the other lost his caregiver as a result of the non-payment. Losing his caregiver placed an increased burden on family members to fill gaps in his care, which was not necessarily sustainable for the long term.

In California, those who use LTSS (referred to as in-home supportive services (IHSS) in California) seem satisfied with the care they have received. For example, those who were using self-directed care options, which allowed them to designate family members for personal care needs and as home care attendants, said this capability has had a positive effect on them. They were pleased that they were able to individualize their care and felt more in control of their health care. However, some noted that the process of qualifying for IHSS was frustrating. As one Spanish-speaking woman explained, her doctor helped her fill out the paperwork to submit a request for IHSS. After an in-home assessment she was denied, but she appealed. After her appeal she received a phone call from a social worker who suggested she drop her appeal because she was likely to be denied again. Her frustration stems from not knowing why she was denied when her doctor was the one who helped her submit the paperwork.

VII. Care Coordination

Care coordination is one of the hallmarks of the Financial Alignment Initiative Demonstration program. The program aims to coordinate medical, behavioral health, and LTSS services through a single health plan for dually eligible beneficiaries. Under the demonstration, each state has specified different levels of care coordination, which can include completing health assessments, developing individualized care plans, establishing interdisciplinary care teams, and ensuring care continuity. However, focus group participants noted limited exposure to these fundamental services of the demonstration, which has shaped their experience with the program.

A. Team Based Approach and Care Coordinators

Overall, those in Worcester seemed to be receiving the most coordination of services and providers. They were also most likely to report they have a care coordinator. Worcester enrollees said they were able to reach out to their care coordinator for help resolving problems. In addition, they believe that their care coordinators act as pro-active advocates to help them manage their health care needs. However, the Worcester participants were unique. Most of the other participants in Boston, Ohio, and California were not receiving this level of coordination or access to care coordinators.

Participants in Boston, Ohio, and California commonly reported they did not feel their care was more coordinated since enrolling in the demonstration program. In addition, most also noted that they did not have a care coordinator. Many of these focus group participants felt as if they did not have someone to turn to for help navigating this new model of care. This has led to much frustration among these participants. In Boston, participants felt there was not enough staff to handle the number of One Care enrollees. Many cited having long waits for return phone calls and others had not met face to face with their care coordinator after six months of being in the plan.

In California, participants were more likely to report that their doctors were their main source of information, but a few said they had a care coordinator. The San Diego participants knew their care coordinator and had a few interactions with their care

coordinator when they first enrolled in the program. However, since that initial enrollment period, they had little to no interaction with their care coordinator. In San Mateo, only one woman said she has a care coordinator. The Spanish-speaking participants in San Diego were most likely to say they did not have a care coordinator.

In Ohio, while most have yet to see an increase in coordinated care services, some said their providers are working closely with one another. However, it was unclear how much of this care coordination is facilitated by the MyCare Ohio plans versus previously established relationship with a group of doctors or care coordinator. For example, some participants noted that they see all of their doctors at the Cleveland Clinic and that these providers all appear to talk to each other and work together as a team. Participants in both sites said they did not have a close working relationship with a care coordinator. Some participants have had multiple care coordinators over the course of the first few months of being enrolled in MyCare Ohio, which suggests that there may be high turnover with care coordinators at the health plans.

Across the focus group sites, when participants have questions about the program not all were sure where or who to turn to for answers. Many said they would call the number on their insurance card for help. Others, especially those in California, said they would ask their doctors for guidance. In Cincinnati, many participants said they do not know who to turn to for answers to their questions regarding MyCare Ohio. However, Cleveland participants more readily said they would turn to their care coordinator. The Boston and California focus group participants seem confused by the overlapping roles of various individuals and organizations involved in their care management. Many have a difficult time identifying the roles played by nurses, social workers, community-based organization staff, and long-term care services coordinators and are confused by the responsibilities of each. So far, participants in these sites have yet to gain clarity on when to turn to each of these individuals and for what purpose.

B. Health Risk Assessment and Individualized Care Plan

Across the sites, most focus group participants were unfamiliar with the purpose of the health risk assessment (HRA) and the individualized care plan. The HRAs are used as a survey tool that assesses beneficiaries' health care needs. Health plans participating in the demonstration are required to develop the comprehensive assessment tool and conduct a HRA with each enrollee shortly after enrolling in the program. However, many of the focus group participants have difficulty recalling if they had a HRA.

Massachusetts was the only site in which the majority of the participants recalled having an initial home visit and assessment. Participants explain that during these home visits and assessments they were often told what benefits they would be eligible for, such as home modifications or personal care attendants. They feel these assessments were taken very seriously and appreciated the sincere concern of those conducting the assessments. As one Worcester man describes, "They really made it better because they ask you all the concerns you have, all the worries that you told them about and they worked on it ASAP."

However, in Ohio and California the number of participants who recalled completing an HRA was much lower (less than half in each site). Of the few participants in Ohio and California who recalled completing a HRA, most said they did not receive any follow-up about the assessment and were not sure when they would receive another evaluation to assess their needs.

The results of the HRAs are utilized to inform the enrollees' individualized care plans, which outline enrollees' health goals, measurable objectives, and health needs. Across all the focus groups, most said they have not received a personal care plan – even those in Massachusetts who had completed the HRA. While a few recall setting short-term, mid-term, and long-term goals for their care, most others were not clear about what a care plan is or how it is supposed to drive the care and services they receive. Furthermore, a number of participants knew they did not have a HRA completed or a care plan in place.

Participants, generally, had not been provided any information regarding the outcomes of their assessment or had not seen a care plan. As a result, a few enrollees had difficulty seeing these elements of the demonstration as important component to this new model of care.

VIII. Costs

When asked about the costs of their care, many participants said their costs have either decreased or stayed the same since enrolling in the demonstration program. They said that their doctor visits, dental and vision care, hospitalizations, and LTSS needs have all been covered by their new plans. They were grateful that they could access these benefits at no cost. However, some participants said their medications and medical supplies now cost more under the program. A few participants experienced some initial charges or costs in the first few weeks of the transition when pharmacists were unaware of their coverage or caregivers were unpaid.

California and Ohio participants reported a mix of increased and decreased pharmacy costs. Some said that under the demonstration they were paying more for their prescription medications, while others said these costs had decreased. For example, starting in 2015, many in San Mateo said they now have a copay for their prescription medications. One woman thinks she will be reimbursed, but no one was sure how to receive a reimbursement from the plan. In San Diego, many had been paying low copays for their prescriptions - between \$1.10 and \$7 – since enrolling in the demonstration. Others said they have no copay for their medications. Still, others said that some of their prescriptions were not covered and they cannot afford them.

In Ohio, a few participants experienced increased costs for things like durable equipment. One Cleveland man explained that certain medical supplies he uses are no longer covered. Other supplies had been scaled back in frequency, such as catheters, gloves, and wipes. He said he now stretches 30 days of supplies over 90 days. To make up the difference he paid out of pocket for the rest of his supplies.

Conclusion

The feedback from the focus group participants across the three states reveals the benefits achieved and challenges that have occurred during the early implementation of the Financial Alignment Initiative Demonstration program. Many of the focus group participants were confused about their coverage and are unaware of all of the services and supports that are available. Some have experienced access barriers, delays and gaps in care during the transition. At the same time, the experiences of some individuals suggest this model of care has potential to improve care for dually eligible beneficiaries. All of the participants valued the new coverage offered under the demonstration and were generally satisfied with the services received.

Perhaps the biggest challenge for the demonstration sites was the general lack of awareness regarding this model of care. Many focus group participants were still unclear how this program was different from the model of care they had before. Program and plan materials did not seem effective in educating consumers about their coverage. What seemed to work best for the focus group participants was a more interpersonal approach to raising awareness about the program – particularly one-on-one interaction with enrollees. The biggest knowledge gaps seem to be around the expanded services enrollees can now access, for example, non-medical transportation services.

Important features of this model of care also did not seem to be well understood and the initial implementation of care coordination services was fragmented. Specifically, some focus group participants had yet experienced a team approach to care or increased care coordination services. Most also did not seem to understand the purposes of the HRA and the individualized care plan. Another big challenge was around the role of the care coordinator – where it is working well, enrollees are very happy, but participants in most sites either report that they have not met with their care coordinator or have already had multiple care coordinators.

Despite these implementation challenges, what seemed to be working across sites was that individuals are, in general, accessing the services they need. While some experienced disruptions initially, such as access to dental services and unpredictable transportation services, things seem to have settled down and enrollees are now getting care without many problems in most cases. The majority of participants were able to keep their providers, which they appreciate. This has added to their comfort with the program. In addition, some individuals were starting to access new services, which they greatly value.

It will be important to revisit these sites at a later point to see how the demonstration is affecting access to care, quality of care and costs of care when implementation challenges are resolved and transition into the model is further along.

ⁱ Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Financial Alignment Initiative. Baltimore, MD: CMS. <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>.

ⁱⁱ Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011. Letter from Cindy Mann and Melanie Bella to State Medicaid Directors regarding "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees." July 8, 2011. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.