

**MEDICARE-MEDICAID
FINANCIAL ALIGNMENT INITIATIVE (FAI)
STATE DEMONSTRATIONS**

**CALIFORNIA CAL MEDICCONNECT
CONSUMER FOCUS GROUPS**

SUMMARY REPORT

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INTRODUCTION - OBJECTIVES AND METHODOLOGY

This report summarizes the results of qualitative research conducted by Alan Newman Research on behalf of the Centers for Medicare & Medicaid Services (CMS).

Background

There are over 11 million Americans enrolled in both the Medicare and Medicaid programs. The Medicare-Medicaid Financial Alignment Initiative (FAI) was designed to facilitate an improved overall care experience, with better integrated and coordinated healthcare services for these Medicare-Medicaid enrollees. Through the FAI, CMS has partnered with states to test two models - capitated and managed fee for service (MFFS) - for their effectiveness in achieving these goals.

While not part of a formal FAI evaluation, this qualitative research was intended to build on past research conducted by RTI International, the independent evaluation contractor for FAI. RTI has conducted focus groups in demonstration states since the beginning of FAI, which explored experiences of Medicare-Medicaid beneficiaries served by state demonstrations under the FAI. Our research was conducted in four capitated model states currently participating in the Initiative – Illinois, Rhode Island, California, and Ohio. This report summarizes the results of focus groups conducted in the state of California. Results from focus groups conducted in the remaining three states will each be provided as separate reports.

Research Objectives

The overall objective of this research was to better understand the beneficiary experience in the Cal MediConnect demonstration in California related to the following key areas: satisfaction with experience in the demonstration, service integration, care coordination, and overall well-being and quality of care of the beneficiary.

Target Audiences

In California, two target audience segments were queried – these included Medicare-Medicaid Plan (MMP) enrollees who make use of Long-Term Services and Supports (LTSS) and MMP enrollees who have many different characteristics (referred to as “General” MMP enrollees for the purposes of this research). Participants were recruited for this research from lists of MMP enrollees provided by the state. A total of 68 participants were queried across all groups. LTSS and General beneficiaries were queried in English, while two groups of Spanish-language General beneficiaries were conducted in Spanish (and translated to English by a professional translator on site). Of the 68 participants, 18 were LTSS, 35 were General (English-language), 15 were General (Spanish-language).

In addition to current enrollment in a participating FAI plan (which was verified during recruiting), participants were also screened to capture mixes of the following:

(Note: Actual plan names from Cal MediConnect MMPs have been masked throughout this report.)

- MMP membership
 - In Los Angeles, 24 had MMP 1, while 13 had MMP 2, 3 had MMP 3, 2 had MMP 4
 - In San Francisco, all 26 participants (11 English-Language and 15 Spanish-language) had MMP 5
- Health conditions (cardiovascular disease, congestive heart failure, COPD, diabetes, stroke, spinal cord injury, among others)
- Time of enrollment with the demonstration (a minimum of 12 months; usually 1-2 years)
- Gender (30 were female and 38 were male)
- Age (1 was age 25-34, 10 were ages 35-54, 23 were ages 55-64, 34 were ages 65-79)
- Education [10 had not completed high school (8 of these were in the Spanish-language groups), 7 were high school graduates, 34 had some college education, 11 were college graduates and 4 were postgraduates]
- Ethnicity (in the English-language groups, 37 were Caucasian, 13 were African American, 1 apiece was Hispanic, Asian, Native American; in the Spanish-language groups, all 15 were Hispanic)

During screening, participants reported that they had care coordinators (although sometimes they contradicted this in group discussion, which was typically due to a misunderstanding of MMP care coordinators and their role prior to group discussion). Screening also ensured the exclusion of beneficiaries who were deaf, in a nursing facility or intermediate care facility for people with intellectual or developmental disabilities. This was done ensure that all participants would be able to attend a focus group facility, feel comfortable, and be able to participate in a group discussion.

Methodology

In order to accomplish the research objectives, a total of ten focus groups were conducted in California, where again, the FAI demonstration is called Cal MediConnect. The groups were conducted in three markets – two in greater Los Angeles (Encino and Beverly Hills) and San Francisco - in the following configuration:

Figure 1: California Cal MediConnect Beneficiary Research: Research Configuration

Segment	ENCINO	BEVERLY HILLS	SAN FRANCISCO	Total
General Beneficiaries (English-language)	2	1	2	5
Long Term Support Services (LTSS) Beneficiaries	1	2	-	3
General Beneficiaries (Spanish-language)	-	-	2	2
Total	3	3	4	10

When reading this report, it is important to remember that focus groups are a qualitative research method. Findings are not projectable to the population as a whole. This report is a summary of findings. Interviews were audio and video recorded, as well as transcribed.

EXECUTIVE SUMMARY OF FINDINGS, KEY CONCLUSIONS, AND RECOMMENDATIONS

Summary of Findings

The following overall findings emerged from the focus group discussions. A detailed summary of these begins on page 16 of this report.

Cal MediConnect Plan Enrollment

California participants became aware of the Cal MediConnect and their plan options through a variety of channels.

- Among English-language participants, these included the following: 1) a letter (from an unrecalled sender, although a few believed it was Medi-Cal or the Department of Social Services) describing the demonstration and options, 2) doctors and provider groups (who frequently motivated them to join their particular plan in order to stay with the practice), 3) a phone call (from unrecalled sources), or 4) other professionals or agencies that helped them with their care.
- Spanish-language participants had been introduced to their plan by doctors (or other staff in the practice), friends, and hospital social workers. They typically knew the name of their health plan provider and that they had Medicare and Medicaid benefits, but they were usually unfamiliar with the term *Cal MediConnect*.

California participants were enrolled in a variety of Cal MediConnect plans. In Los Angeles, most were with MMP 1, some were with MMP 2, and a very few had MMP 3 or MMP 4. In San Francisco, all participants had MMP 5 (which is the only plan serving that county). Across groups, they reported a mix of having actively selected or been passively enrolled in their plans.

- Among English-language participants, roughly half had actively selected their current plan, usually at their doctor's recommendation and without looking at other options, but, in a few cases, after comparing multiple plans. If they had compared plans, their selection criteria often included the presence of their preferred provider in plan networks and access to specific benefits like transportation and a health club. The rest, who were passively enrolled in plans, had either decided not to choose a plan or felt they had been "put into" a plan without a choice.
- Spanish-language participants did not recall how they were enrolled in their plans. They did not articulate any plan decision making or comparison process, which suggested that they were passively enrolled.

Overall, English-language participants usually had a good working understanding of insurance, their plans, and the health care system in general, while Spanish-language participants expressed more confusion and uncertainty in these areas

Overall Satisfaction in Cal MediConnect Plans

Participants across all segments - General, LTSS, Spanish-language - reported high satisfaction with their Cal MediConnect plan experiences. They rated their satisfaction on a scale of 1 to 5 (where 1 was *Not at all Satisfied* and 5 was *Very Satisfied*). Of the 68 total beneficiaries queried, the vast majority (61) rated their satisfaction with either a 4 or 5 (i.e., 39 gave ratings of 5, while 22 rated it a 4). Of the rest, six rated theirs a 3, and one rated it a 2.

- Overall, most were pleased and grateful that they had access to health care coverage. Across all groups, other elements that promoted their satisfaction included good coverage for medical care (with no costs, including copays) and prescriptions; access to additional benefits (e.g., dental, vision, hearing aids, transportation, health clubs), access to good quality health care providers, convenient location of participating providers (i.e., close to home), and attention to and follow-up by the plan or coordinator regarding personal health and individual needs.
- In Los Angeles participants also mentioned the following: ease of getting referrals and seeing specialists promptly and good customer service at Member Services. In San Francisco, Spanish-language participants cited the availability of Spanish-speaking plan representative and health care providers as an important reason for their satisfaction. (Participants reporting indicated that this sometimes occurred.)
- Key reasons for diminished satisfaction included the following: limited dental and vision coverage, administrative and billing issues or errors, and difficulties related to transportation services (e.g., lateness, no-shows). A few English-language participants also cited being referred to unsatisfactory providers or facilities and being frustrated when health care or other services providers lack fluency in English. Spanish-language participants were less satisfied when they were paired with providers who did not speak Spanish and they needed to rely on interpreter.

Overview of Care Coordination Influences

According to participants, the coordination of their care had multiple influences – both personal (self, family) and external (doctors, Cal MediConnect plan representatives, and other professionals).

- Virtually all participants had at least some – and usually a significant – role in organizing and overseeing their own care, often in conjunction with their doctors. However, English-language participants had the most confidence in their ability to oversee their own care, while

Spanish-language participants seemed to need more outside help to so. (This was due to general confusion health care system, lack of confidence in their ability to navigate it, and language barriers.)

- Family members were often very involved in Spanish-language participants' care – these participants frequently needed their adult children to help them navigate the health care system. A few English-language participants had family members who helped them, but many seemed to lack intensive family support. English-language participants' family members did not seem to communicate with care coordinators, while Spanish-language participants' family members, sometimes did, especially during acute health events.
- Roughly half of all participants in Los Angeles and a few in San Francisco (primarily in the Spanish-language segment), felt they currently had a care coordinator from their plan, or, in a few cases from their provider group, whom they could contact directly. Of these, about half described a very involved care coordinator (and were, without exception, very positive about this person's help), while the rest, who were usually lower-need, had one they viewed as “in the background.” Most recalled having been assigned or contacted by someone whom they thought was a care coordinator after they enrolled in the plan, but not all had maintained a care coordinator relationship.
- About a quarter of all English-language participants considered their primary care provider to be the main coordinators of their care. It was not clear if any Spanish-language participants did, although they regarded their providers as an important part of their overall care.
- The rest either did not have or did not perceive that they had a care coordinator. Among English-language participants, reasons for lack of a dedicated care coordinator were cited, including personal preference (frequently, declining one when it was offered by the plan) or having general difficulty connecting with one, due to communication lapses or turnover. Among Spanish-language participants, some did not seem to know that care coordinators were available through their plans. In both language segments, but especially among some Spanish-language participants who were fearful of fraud, skepticism and suspicion were barriers to accepting initial care coordinator contact. Even if they eventually connected with one, they had first been wary of an unknown person calling them or asking to visit them.
- Even if participants perceived that they lacked a dedicated care coordinator, they still received attention and input from their plans, which they valued. Most described being contacted by unidentified plan representatives on a relatively frequent and regular basis. Reasons for this plan contact were care-coordination-oriented and included needs assessment, offering services, medication management, and general “check in” calls about their health and wellbeing.

It was difficult to tell if these participants were, in fact, being contacted by care coordinators because they were unsure. However, they did not describe a personal connection with one

person from the plan, and some seemed to be hearing from different people. For some, it was also hard to differentiate who was calling them, especially if they were receiving contacts from a mix of sources, such as their plans, health care providers and other organizations. Spanish-language participants, in particular, tended to refer to multiple helping influences interchangeably (e.g., care coordinators, nurses, social workers).

- In addition, English-language participants often contacted Member Services, sometimes by preference and sometimes because they felt it was their only option. Spanish-language participants did not mention Member Services, but in general, they tended to prefer being proactively contacted - they often appeared to lack confidence for making calls unless they had a personal relationship with the person they were calling.

Participants who knew they had dedicated care coordinators varied in terms of how integrated care coordinators were in their lives and care. This seemed to be largely dependent on their personal level of need and their receptivity to outside help.

- Higher-need LTSS and General beneficiaries – such as those whose independence was limited by health or mobility issues, and sometimes, additional self-described mental health concerns – reported having the most involved care coordinators. They received the most frequent contact and offers of help and services from their care coordinators.
- More self-sufficient participants usually received regular or occasional check-in calls from their coordinators. They also might initiate contact if they had a problem they could not solve on their own. In general, these participants’ care coordinators seemed to be an appreciated but relatively background influence.
- Some English-language participants, particularly in Los Angeles, had experienced care coordinator turnover or lapses in contact with a care coordinator, and as a result they were underwhelmed by their care coordinator experiences so far.

Additional Care Coordination Topics

Across groups, participants usually described relatively regular contact from either their care coordinators or “someone” from the plan.

- Consistently, participants reported being contacted by their plans by phone to complete an initial and then annual or semi-annual needs assessment questionnaire (during which they were also made aware of services) and for patient satisfaction surveys. Those who felt they lacked care coordinators often said they were contacted from time to time by “someone” from the plan to “check in” about their health and needs.
- Participants with care coordinators usually described regular telephone contact (monthly, every two months, or quarterly), which was sufficient. If an acute medical situation occurred, coordinators usually increased their contact frequency. A few participants wanted more care

coordinator contact – they had experienced long lapses in communication, coordinator turnover, or what they perceived as general inattentiveness. A few said they avoided care coordinator calls or did not return them, unless they needed something.

Across groups, several participants had received home visits, either from care coordinators or from other professionals as facilitated by their plans. Some had received a home visit from their care coordinator, or someone they thought was care coordinator, around the time they enrolled in their plan or during a care transition. However, home visits did not seem to be a regular or expected part of the care coordinator relationship for many. In addition, several had been visited at home by health care providers who were part of the plan, either for care after an acute health event or, in some cases, for primary care.

Participants usually appreciated home visits, whether from care coordinators or others with an interest in their health, such as health care providers. In contrast, home visits were less appealing to a few, who found them intrusive. A few Spanish-language participants perceived that part of the reason for any home visit, including visits by medical personnel, was to ensure they were being honest about their needs.

Care coordinators provided support in a wide variety of ways and to varying extents – often according to participants’ level of need. Participants were especially impressed and thankful when care coordinators anticipated or recognized their needs. Higher-need participants particularly valued their care coordinators, with whom they seemed to have developed a personal rapport.

- Participants’ comments suggested that the most important areas of care coordinator assistance were as follows: assessment of initial and ongoing needs, medication management, help during care transitions, and finding doctors and service providers who accept the plan. Care coordinators’ ability to arrange for nursing or physician care in the home as needed, get doctor’s appointments made sooner, resolve administrative problems (such as erroneous bills and prescription coverage disputes), assess potential needs for in-home services, and provide general emotional support were also valuable to participants.
- Participants who viewed their care coordinators as “in the background” had not taken advantage of much care coordinator help, but they were appreciative when their care coordinators asked about their needs and made them aware of or offered services, even if they declined them.
- English-language participants did a lot of practical care coordination tasks, such as making their appointments and communicating with service providers, on their own, unless they were higher-need or during acute health events. In these cases, care coordinators got more involved. Spanish-language participants needed more help handling health care tasks, such as making appointments, which they sometimes got from care coordinators or others affiliated with their plan.

Assessment of Needs, Care Goals, and Care Plans

Across groups, participants described a mix of ways in which their individual needs had been assessed when they joined their Cal MediConnect plan. Many recalled completing a plan-administered questionnaire, usually by phone, around the time of their enrollment and then, sometimes, at regular intervals thereafter (e.g., every 6 months to a year). Care coordinators or other plan representatives usually also called participants periodically to ask them about their needs.

Participants usually did not perceive that they had created care plans since joining a Cal MediConnect plan. When provided with a description of a care plan, many said it was not familiar to them. However, some English- and Spanish-language participants did describe more informal goal setting and accountability related to either physical or behavioral health. This occurred with either their care coordinators or their doctors. These were informal unwritten plans developed during conversations over the phone or in person. Care coordinators or doctors followed up on their progress, which seemed to be both positive and motivational for them.

Participants were asked if, since enrolling in their Cal MediConnect plan, they had been made aware of resources that were available to them. Across groups, participants frequently did feel that they had been offered a variety of services, usually more than they had before they joined their plans.

- This was especially the case among Los Angeles participants, who seemed to be getting the most contact and reminders from their plans about what was available to them, and where there was a moderate incidence of care coordinators.
- While English-language participants in San Francisco seemed to be generally well aware of available services, they did not report as much plan outreach about services. As mentioned, above, very few had dedicated care coordinators from their plan.
- Some Spanish-language participants seemed to have a fairly strong understanding of the benefits that were available to them, especially if they had care coordinators; however, a number of others were unaware of their benefits and unsure of how to find out more about them.

Additional Benefits Discussion

Most English- and Spanish-language participants, both users and non-users of transportation services, were aware that their plans offered a transportation benefit, and it was an essential benefit for a number of them.

- Many, particularly in the English-language groups, were positive about transportation services. They were pleased that the rides were free, convenient, usually prompt, and provided by a courteous driver. They were especially pleased that many drivers would help

them with their medical equipment and help them to and from the door. Only a very few described negative experiences with drivers, including one who said their courteousness could be “hit or miss.”

- However, some in both Los Angeles and San Francisco had experienced late pickups, no shows, and long wait times to be picked up at the doctor’s office after their appointment was over. They saw this as a serious problem with the benefit, and it made them wary of depending on it. A few disliked the advance planning required to schedule a ride and the resultant lack of immediate access. Some Spanish-language participants disliked it when they were picked up by a driver that did not speak Spanish.

Across all groups, no participants were familiar with the term Care Plan Options. When provided with a description of it (and some examples of the benefits it might include, such as home modifications), some thought these sounded appealing, but they were not aware of any way to get them from their plans

LTSS Discussion

Most LTSS participants were currently receiving In-home Supportive Services (IHSS), and they seemed to be quite familiar with how the IHSS system worked. In most cases, their IHSS access had preceded their plan enrollment. They saw IHSS as a benefit offered by the county. They did not associate getting IHSS with their Cal MediConnect plans, but they said plan representatives had mentioned these services. In contrast, a very few participants had accessed IHSS after plan enrollment. They were not sure exactly how this had happened, but one said her plan had “brought in a social worker” to set up IHSS for her. Participants were usually quite positive about IHSS and the help it provided. They expressed gratitude and relief for having access to IHSS, but they frequently noted that it is difficult to find and keep a reliable, suitable IHSS worker.

LTSS participants discussed care transitions in greater depth than those in the General segment. Some had been in the hospital or a nursing home since their Cal MediConnect enrollment. Of these, most were positive about the support they received when they came home, although their recall of the experience often seemed to be limited. Overall, their transitions seemed to have been supported by combined efforts from their plan or plan care coordinators, their doctors, and the hospital. In contrast, a very few described hospital stays after which they received little or no support from anyone.

Impact of Cal MediConnect on Health, Well-Being, and Quality of Life

Most participants felt that being enrolled in a Cal MediConnect plan had positively affected their lives. Participants were usually hesitant to say that their health was better because of Cal MediConnect, because they were aging, had chronic conditions, or had enrolled in the

plan after becoming sick. However, many noted that they now took better care of themselves and were encouraged to do so by the plan – such as via check-in calls from care coordinators.

- In Los Angeles, participants were particularly positive about the impact of their Cal MediConnect plans. Several compared their plans positively to their previous coverage in that they were offered more services and it was easier to get the care they needed. This included ease of getting referrals, ease of getting prescriptions filled, access to preferred facilities (i.e., “not just the county hospital”), access to non-medical services, like dental and transportation, and access to conveniently located network pharmacies.
- In San Francisco, English-language participants were grateful for their coverage, but they were less effusive about its positive impact on their lives than those in Los Angeles. At this point in the discussion, some were individually focused on specialized features that were not available to them through the plans, such as treatments for Lyme disease that were not covered, chiropractic coverage, and coverage for particular drugs.
- Spanish-language participants were generally quite positive about their plan’s impact on their lives. However, a few Spanish-language participants realized as a result of the discussion that they lacked knowledge about benefits that might be available to them.

A few English-language participants commented positively about the fact that Cal MediConnect combines Medicare and Medicaid into one program. They felt this made using their coverage simpler and easier.

Key Conclusions and Recommendations

The following key conclusions and associated recommendations emerged from this research and will be worth considering as state moves forward with Cal MediConnect in the coming year.

The Cal MediConnect MMPs appear to be offering a valuable and generally effective care coordination benefit to beneficiaries. Plans seem to be accomplishing care coordination through a mix of both dedicated care coordinators and more general contact that occurs directly between plans and beneficiaries (for example, “someone” from the plan contacts beneficiaries periodically, beneficiaries call Member Services as needed). Recognizing that plans and individual beneficiaries’ situations can vary, the care coordination aspects of Cal MediConnect plans usually enhance beneficiaries’ care, increase their awareness of access to benefits and services, and contribute to their perception that Cal MediConnect plans improved their overall quality of life.

- **Recommendation.** Cal MediConnect plans should work to continually improve their care coordination benefit and then periodically survey beneficiaries - especially those with more intensive health needs (e.g., LTSS beneficiaries who use care coordination services more often) – to diagnose potential problems related to important elements of successful beneficiary-care coordinator relationships. For example, these could include frequency of

contact, level of attentiveness, and experience and satisfaction with home visits. Once problems have been diagnosed, Cal MediConnect plans can then occasionally query beneficiaries to determine how any previously identified issues are resolved over time.

When enrolling, beneficiaries frequently do not understand that care coordination is a distinct feature of Cal MediConnect plans. They eventually experience aspects of it, but at first, they are sometimes confused by calls and offers of services from the plan or care coordinators. After some time in the plan, especially if they are low utilizers of care coordinator help, some are still uncertain of the care coordinator's role in particular, what they can expect from the care coordinator, what the care coordinator can help with, and how the care coordinator is functioning on their behalf.

- **Recommendation.** Plans should work to communicate the care coordination benefit to beneficiaries through multiple modalities and multiple touch points. Communicate the availability of care coordinators, what can be expected of them, and the value of accepting help from them. It is especially important that this occurs during the onboarding process and that it be reinforced periodically thereafter.

There appear to be opportunities for 1) increasing the number of beneficiaries who have care coordinators and 2) strengthening existing beneficiary-care coordinator relationships. Care coordination occurs most effectively when a consistent, ongoing personal relationship between coordinator and beneficiary is established. In both Los Angeles and San Francisco, there were a number of participants who either said they did not have care coordinators, who regarded them as an unimportant background resource, or in a few cases, had lost touch with care coordinators. Elements of this process of strengthening care coordination could include a clear introduction process, regular phone contact, introductory or occasional home visits (when practical and for higher-need beneficiaries), and consistency of care coordinators.

However, establishment of these relationships can be challenging for care coordinators especially when beneficiaries value their independence and privacy, are resistant to outside help, or deliberately ignore care coordinators' attempts to contact them. In addition, care coordinator turnover is particularly disruptive for beneficiaries, and, especially if it happens multiple times, increases the likelihood that they will disengage from care coordinator relationships.

- **Recommendation.** Cal MediConnect plans could be queried regarding their efforts to retain care coordinators, as well as what processes are in place to ensure smooth beneficiary transition to a new care coordinator when turnover inevitably occurs. If opportunities are found for improving and refining these processes, these could then be addressed.
- **Recommendation.** Especially for higher-need beneficiaries, home visits are a positive, supportive aspect of the beneficiary-care coordinator relationship, but there can be uncertainty among beneficiaries about their purpose. Plans should work to increase beneficiary understanding of reasons for home visits (including that no benefits will be taken

away as a result of them). MMPs could also be queried regarding how they communicate about home visits to beneficiaries and what challenges they face in engaging beneficiaries in this way.

- **Recommendation.** Plans might consider providing care coordinators with training, strategies and insights regarding how to effectively but respectfully encourage resistant beneficiaries to accept their communication and help. In particular, this training could focus on how to compellingly convey to beneficiaries what kinds of help care coordinators can provide and the potential value this has for them. Plans could be queried to understand how they balance the need to reach higher-need beneficiaries with barriers to this (such as their resistance to outside help).

Care coordinators can be a key liaison between beneficiaries, the benefits available to them their plan, and other resources available to them in the community. Care coordinator input helps beneficiaries recognize the extent of the care and help that is available to them.

- **Recommendation.** Cal MediConnect plan care coordinators should continue to focus on increasing beneficiaries' awareness of, and connection to benefits and services. Offering services and help, even if beneficiaries decline, has the dual benefit of making the beneficiary feel well-supported and letting them know what is available if they need it. For example, care coordinators made beneficiaries aware that they might be eligible for in-home services – and while they often declined these, they knew that the option was there.

Cal MediConnect beneficiaries sometimes have difficulty resolving administrative issues that arise – they need help to navigate insurance and medical systems. Examples of such issues included being billed for services in error (which can cause some to think they have to pay), having to wait a long time for a necessary doctor's appointment, needing to find a doctor or provider who accepted their plan (such as if theirs left the network) or denial of coverage for drugs at the pharmacy. When care coordinators intervene on their behalf and get resolution, this is extremely helpful to them. This is a key way that care coordinators add value, even for lower-need beneficiaries who did not need much but could benefit from this kind of practical help.

- **Recommendations.** Plans (and care coordinators) should ensure that beneficiaries know they can ask their care coordinators for help when they cannot solve these types of problems on their own. Plans could accomplish this through messaging to beneficiaries in plan communications, while care coordinators can reinforce this message during their interactions with beneficiaries. Beneficiaries also need to be assured of and reminded by their plans that they should not ever be billed. This could include ensuring that this is clearly indicated on the back of all Cal MediConnect plan cards (if this is not already the case).
- **Recommendation.** Plans could be made aware that provider network adequacy is an important problem for some beneficiaries that they should work to address, as it can both frustrate beneficiaries and delay access to care as they seek in-network providers who are

accepting new patients. While these beneficiaries ultimately find care, this process can be difficult for them. In addition, plans should be attentive to ways they can help beneficiaries to manage provider transition, including getting help from their care coordinator.

Beneficiaries who had done so valued setting goals for their health and being held accountable to them, by their care coordinators or their doctors. However, beneficiaries often reported low awareness or recall of care plan development and implementation – which might have been due in part to a lack of connection with care coordinators.

- **Recommendation.** Plans should ensure that care plans are being developed, work on refining this process, and ensure that beneficiaries are being actively engaged in their care plans.

Transportation benefits are critical to some Cal MediConnect beneficiaries' ability to access medical care. When well executed, transportation services are highly valued, but when poorly delivered they are quite problematic. Unreliability was seen as too common by some beneficiaries, who were wary of relying on the service now.

- **Recommendation.** Plans should continue to look for ways to improve this service, given its important to many beneficiaries in accessing their care.

As a beneficiary segment, Spanish-language participants have some additional unique needs and characteristics. Access to very involved care coordinators appears to be immensely helpful to these beneficiaries, who need guidance to address their confusion and fears associated with insurance and the health care system. With care coordinator help, their awareness of and likelihood of accessing services seems to increase significantly

Recommendation. MMPs should work to incorporate the following on behalf of Spanish-language beneficiaries whenever possible:

- Proactive contact from a care coordinator or other plan representatives – Spanish-language participants are unlikely to initiate contact, especially with unfamiliar individuals.
- Access to Spanish-speaking care coordinators, health care providers, and service providers.
- Use of interpreter services only when unavoidable, understanding that, for many, this contributes to a sense of disconnection and confusion.
- Access to materials in Spanish, written simply and in colloquial Spanish to account for the lower educational levels common in this segment.

Recommendation. When developing their Spanish-language outreach efforts, MMPs should also take into consideration some general audience characteristics that also occur among Spanish-language beneficiaries, including the following: reliance on family support, including the likelihood that family will get involved with care coordinators, a preference for verbal explanation of information and the personal connection associated with this, concerns about fraud when contacted by unknown parties offering services, likelihood to resist some help (even

when it is needed) due to personal pride or the belief that others in the community need it more, and fears about having benefits taken away if they share negative survey feedback or accept home visits.

In conducting this research with Cal MediConnect beneficiaries, it has become evident that, while there are many similarities in their experiences across plans, experiences do indeed vary by plan. Cal MediConnect plans vary operationally and according to what additional benefits they offer.

- **Recommendation.** If there is an interest in providing direction to the individual Cal MediConnect MMPs, including identifying plan-specific opportunities for improvement, future research will need to be structured accordingly – i.e., by segmenting beneficiary audiences by plan provider and querying them in separate focus groups.

GENERAL DISCUSSION OF CAL MEDICONNECT: OVERALL EXPERIENCES AND SATISFACTION

The groups began with participants describing how they became aware of and enrolled in their Cal MediConnect plans. Then, they briefly identified aspects of their Cal MediConnect experiences that had worked and not worked well for them. Finally, they rated their overall satisfaction with their experiences in their plans thus far and explained the reasons for their ratings.

Enrollment in Cal MediConnect Plans

Participants' awareness of the term Cal MediConnect varied by language segment, but most participants across groups seemed to know what insurance they had and that it involved both Medicare and Medicaid benefits.

- English-language participants were aware that they had a Cal MediConnect plan and that this had replaced their previous Medicare and Medicaid coverage. While they were not usually clear regarding how or why this change had occurred, they usually remembered that it had happened. Overall, they had a strong working understanding of their plans and the health care system in general, especially many were frequent users of both.
- Spanish-language participants were not usually familiar with the term Cal MediConnect. However, they typically understood that they had an insurance plan, knew the name of their health plan provider, and also frequently referred to their insurance as "Medicare and Medi-Cal." Participants were sometimes confused about the specifics of their coverage. Those who had used their coverage a lot for medical issues, as well as those few who reported having past employer-sponsored coverage seemed to have the best working understanding of their plans.

Sources of information. Across groups, participants were asked how they first became aware of and involved in their Cal MediConnect plan.

- English-language participants discussed this in greatest depth and described the following ways of learning about Cal MediConnect:
 - **Letter.** Across groups, some participants said they had been notified in an official letter or some type of mailed communication that they were eligible for and would be enrolled in their Cal MediConnect plan. They did not usually recall the sender, although a few thought it was from Medi-Cal or the Department of Social Services. Selected participant comments regarding this included the following:
 - ✚ "I believe I was sent paperwork that I needed to change...I needed to choose a plan." (General, Beverly Hills)
 - ✚ "I got mail from Medi-Cal...I was with Medi-Cal before MMP 2." (General, Encino)

- ✚ “I got mail saying I had to make a decision where to go...I was with Medicare-Medicaid. Then it turned into MMP 1.” (General, Encino)
- ✚ “I originally had the MMP 5...and then you get a letter that basically states that if you do nothing, you get transferred to the Cal MediConnect. Otherwise you’re back picking a new plan.” (General, San Francisco)

However, a number of others did not recall receiving any kind of official letter regarding Cal MediConnect – they had been alerted to their Cal MediConnect options in other ways, particularly by their doctors. A few mentioned receiving marketing information from health plans but did not seem to understand that this information was related to Cal MediConnect (or they were not sure).

- **Doctors and provider groups.** Several participants described being made aware of their Cal MediConnect plan by someone related to their primary care physician. Often, this was the physician directly, but in some cases, it was a practice or hospital employee or an insurance representative who was visiting the office. Participants’ comments suggested that their providers had joined plan networks and then given their patients the opportunity to enroll. Usually, they were motivated to join the plan in order to stay with their doctors. Comments to this effect included the following:

- ✚ “I was at my doctor’s office and this guy came out...he worked for the practice. And just told me to sign here. Next thing I know, I got a card with their membership information in the mail.” (LTSS, Beverly Hills)

- ✚ “There was a rep [my doctor] had hired to explain Cal MediConnect, an insurance specialist – that the Medi-Medi was changing to Cal MediConnect, and these are some of the options – but that he [my doctor] went with this particular option. I immediately jumped on it, because I didn’t want to lose my primary.” (General, Encino)

- ✚ “I think I was almost forced into it, and it was through my physician. I think I had to sign up to stay with him.” (General, Beverly Hills)

- ✚ “My doctor insisted that I sign up for it.” (General, San Francisco)

- **Phone call.** Several participants also said they received phone calls regarding Cal MediConnect plans. Participants could not specify who these calls were from. As one described this, “I don’t [remember who called]. I just remember that someone called and said, ‘Would I be interested in being in Cal MediConnect?’” (General, Beverly Hills). Said another, “I got a call...they called me about MediConnect...and they called a couple of times...then they started sending letters” (General Beverly Hills).

- **Professional or agency.** A few participants were introduced to Cal MediConnect by a professional or agency in their life who helps them with their care. This was especially mentioned in San Francisco, where one General beneficiary had been directed to Cal MediConnect by her mental health counselor, another enrolled after being told about it when calling the county, and one who was referred to it after qualifying for disability benefits. In Los Angeles, a very few enrolled in Cal MediConnect after direction to it from Medicare – such as one who said, “They [Medicare] hooked me up with MMP 1” (LTSS, Encino).
- **Friends.** A very few had heard about Cal MediConnect coverage through friends. For example, one reported having selected her plan because a friend was already a member - e.g., “His plan was a lot better than mine [at the time], so I looked into it.(LTSS, Beverly Hills).
- Spanish-language participants mentioned a few ways in which they had learned about Cal MediConnect plans, including from their doctors (or a nurse or other staff at their doctor’s office) friends, and hospital social workers. One participant described meeting with a representative – i.e., “I went to visit my friend [who was meeting with someone about a plan] – so I asked the person if I could apply [too]” (Spanish Language, San Francisco). Another mentioned that he had received phone calls from what he assumed were insurance providers - i.e., “Certain companies, they contacted me, so they could enroll me” (Spanish Language, San Francisco).

Plan decision making. Across groups, there was some discussion about how participants became enrolled in the plans they have now.

- Participants in the English-language groups reported a mix of actively selecting Cal MediConnect plans or being passively enrolled in them. Many of those who felt they had selected a plan chose the one their doctor recommended and did not seem to have considered any others.
 - Overall, most participants had not done much comparison across plans on their own. This was especially the case in San Francisco, where MMP 5 seemed to be the “default” plan for participants (and they all had it). However, it was also true in Los Angeles, where participants were not always aware of all of their plan options. For example, some perceived they had only two choices – e.g., “I felt there was only MMP 1 and MMP 2” (Encino, LTSS).
 - However, a few in Los Angeles and one in San Francisco had compared plans, particularly if they were looking for a plan with specific benefits. For example, one participant commented, “They [my plan provider] had the best hospital, better than the other ones in the area. And they covered hearing aids” (LTSS, Beverly Hills). Said

another, “They gave me a list...and I went over everything and I chose MMP 5”
(General, San Francisco).

Roughly half of all English-language participants described being (or seemed to have been) automatically enrolled in their current plan. Several of these seemed, at the time, to have had no idea how or why this happened. Illustrative quotes are as follows:

- ✚ “They put me on MMP 1 automatically – the state [did].” (LTSS, Encino)
- ✚ “I was switched [to MMP 1 from Medi-Medi] without my knowledge, I guess because they couldn’t reach me.” (General, Encino)
- ✚ “I have no idea how I got on it.” (General, Beverly Hills)
- ✚ “I don’t remember a call or a letter. It just happened one day. I was there.” (General, Beverly Hills)
- ✚ ”I really don’t remember how – but it’s almost like it was pushed on us. I really don’t remember signing up for it.” (General, San Francisco)

- Spanish-language participants did not usually recall how they had been enrolled in their current plans. Most did not clearly articulate any plan decision-making or comparison process during the discussion, which suggested that many were likely passively enrolled in their plan. One described this experience as follows: “I went to Social Security...and then I followed up through Medicare, and then I realized I was already enrolled in MMP 5. So, they pretty much enrolled me automatically” (Spanish Language, San Francisco).

General Overview of Experience in Cal MediConnect

Across all groups, participants briefly described what had and had not worked well for them in their Cal MediConnect experiences. Top-of-mind responses across English- and Spanish-language groups were usually similar and can be generally summarized as follows:

- Most were generally positive about having access to Cal MediConnect benefits, particularly because they felt they had good coverage for medical care and prescriptions at no cost (including no copays or bills).
- Many greatly valued having access to dental, vision and (in some cases) hearing aid coverage - as well as transportation benefits.
- Several described being made aware of (and helped to access) additional services that were available to them (e.g., in-home care after hospitalizations, health club memberships, etc.) – either by “someone” from their plans or by care coordinators.
- Some English-language participants were pleased at what they described as ease of getting referrals from the plans and getting prescriptions filled.

- Several were frustrated by limitations on dental and vision coverage, and in a few cases with unsatisfactory or poor-quality dentists and vision providers.
- A few English-language participants (especially in Los Angeles) had difficulty finding health care and service providers who accepted their coverage or with whom they felt comfortable.

At this point in the discussion, participants focused mostly on their access to coverage and practical aspects of their plans (e.g., ease of getting referrals) – they did not say much about care coordinators. However, throughout the discussion as the topic arose, participants with very involved care coordinators were quite positive about their help and support. In contrast, there were a few participants (either who described very distant relationships with care coordinators or who did not feel they had one at all), who expressed general frustration about high turnover or inconsistent care coordinator contact.

Overall Satisfaction with Cal MediConnect Experience

Across groups (and before their Cal MediConnect experiences were explored in depth), participants were asked to rate their satisfaction on scale of 1 to 5, where 1 is *Not at All Satisfied* and 5 is *Very Satisfied*.

- Overall, most participants reported high satisfaction with their Cal MediConnect plans and their experience in the demonstration. Satisfaction ratings were high in both the General and LTSS beneficiary segments.
- Of the 53 total English-language beneficiaries queried, the vast majority (46) rated their satisfaction with either a 4 or 5 (i.e., 24 gave ratings of 5, while 22 rated it a 4). Of the rest, six rated theirs a 3, and one rated it a 2).
- Of the 15 total Spanish-language beneficiaries queried, all rated their satisfaction with a 5.
- Participants’ Cal MediConnect plan satisfaction ratings are summarized in the following table:

Figure 2: Participants’ Cal MediConnect Overall Plan Satisfaction Ratings by Market and Segment (Scale of 1 to 5 where 1 = Not at all Satisfied and 5 = Very Satisfied)

ENCINO

<i>Ratings</i>	5	4	3	2	1	
General	2	5	1	-	-	8
General	2	5	1	-	-	8
LTSS	3	3	-	-	-	6

BEVERLY HILLS

<i>Ratings</i>	5	4	3	2	1	
LTSS	4	2	-	1	-	7
LTSS	3	-	2	-	-	5
General	4	4	-	-	-	8

SAN FRANCISCO

<i>Ratings</i>	5	4	3	2	1	
General	5	-	-	-	-	5
General	1	3	2	-	-	6
Spanish-language	7	-	-	-	-	7
Spanish-language	8	-	-	-	-	8

TOTAL

<i>Ratings</i>	5	4	3	2	1	
	39	22	6	1	-	68

Reasons for ratings. Participants discussed the rationales for their ratings.

Factors that contribute to satisfaction. Reasons for their high satisfaction were similar across markets and English- and Spanish-language groups – but with a few market and language-segment distinctions as noted below:

Mentioned in all Los Angeles and San Francisco groups

➤ **Good coverage for medical care and prescriptions** (*this was mentioned by many participants*)

✚ “I have no complaints. I haven’t had to pay for anything – and I don’t make enough money to pay for my own doctors.” (General, Encino)

✚ “My shoulder hurt really bad and someone at the clinic said, ‘They [the plan] probably won’t take care of that.’ Well, they did. I got an MRI and physical therapy.” (General, Beverly Hills)

✚ “I had throat cancer. That’s what this scar is. I went right in. The diagnostic was paid for. It saved my life. MMP 1 saved my life.” (General, Beverly Hills)

- ✦ “I do appreciate all that it [MMP 5] has provided me with so little to pay out of my pocket.” (General, San Francisco)
 - ✦ “I’ve never been denied [coverage].” (General, San Francisco)
 - ✦ “I never had medical coverage [before this] because it was so expensive.” (Spanish Language, San Francisco)
 - ✦ “I’m really thankful for all the benefits and services they are giving me.” (Spanish Language, San Francisco)
- **Access to additional benefits – such as dental, vision, hearing aids, transportation, health clubs** *(this was mentioned by several participants)*
- ✦ “It covers so much more dental [than what I had before]...that has been a lifesaver for me.” (General, Encino)
 - ✦ “Right now, they [my plan] pay \$200 toward my glasses - so it’s going to be free for the eyeglasses. And dental, it’s much better than I was getting [before Cal MediConnect].” (LTSS, Beverly Hills)
 - ✦ “The hearing aid benefit is wonderful.” (LTSS, Beverly Hills)
 - ✦ “I’m grateful for the transportation.” (LTSS, Beverly Hills)
 - ✦ “I use the transportation to get to my doctor’s appointments, procedures and stuff. It works very well.” (General, San Francisco)
 - ✦ “What I like about the MediConnect is that they added transportation to this program.” (General, San Francisco)
 - ✦ “The taxi ride. That is what I love.” (General, San Francisco)
 - ✦ “We can go to the eye doctor and the dentist.” (Spanish Language, San Francisco)
 - ✦ “They have taxis to go to the doctor or the dentist, [and] care in the house.” (Spanish Language, San Francisco)
- **Access to professional, caring, well-regarded health care providers** *(this was mentioned by several participants)*
- ✦ “They’ve been really great. They send me to the best doctors and specialists.” (General, Encino)
 - ✦ “The doctors I see care – and that makes a big difference to me.” (General, Encino)
 - ✦ “Every time I have to go to a doctor, the doctor seems to be pretty reliable and caring.” (General, Encino)
 - ✦ “I’ve been lucky – I found me a really good primary doctor.” (LTSS, Encino)

- ✦ “I have a fabulous primary care doctor.” (General, San Francisco)
 - ✦ “They’re really nice and everything...the doctors. The hospital is really nice. I haven’t had any problems so far.” (General, San Francisco)
 - ✦ “The doctors are fabulous.” (Spanish Language, San Francisco)
 - ✦ “I really like the physicians, the clinics – and I am very pleased with the emergency room.” (Spanish Language, San Francisco)
- **Contact, communication, and follow-up from the plan (or individual care coordinators) about overall health, well-being, and needs** (*this was mentioned by a few participants*)
- ✦ “I couldn’t be more enthusiastic about it...Every time they [my plan] calls me I go, ‘Oh my God, they’re so awesome. They just called me again.’ They call regularly to see if you’re okay. [They ask] ‘Do you need this? Do you need that?’” (General, Beverly Hills)
 - ✦ “A representative [from LA Care] came out and she talked to me. I feel - it’s like I have a chance to do some things myself. It’s like a partnership...I watch my weight. I realize they’re there to remind me.” (General, Beverly Hills)
 - ✦ “They are attentive to me. I have people assigned to me. There is a nurse assigned to me.” (Spanish Language, San Francisco)
- **Convenient location of health care providers who accept the plan** (*this was mentioned by a few participants*)
- ✦ “I live across the street from my doctor. He’s from here to my front door.” (LTSS, Beverly Hills)
 - ✦ “With MMP 5...the places I have to go for my medical care are convenient to me. Close to home or still within driving range.” (General, San Francisco)
 - ✦ “Because everything is close to my home...I don’t have to be struggling too much. I don’t have to be in many places.” (Spanish Language, San Francisco)
 - ✦ “The doctor is close by. Emergency is close by. I like it.” (Spanish Language, San Francisco)

Mentioned in Los Angeles groups

- **Ease of getting referrals and seeing specialists in a timely manner (referrals sometimes originated from the plan and sometimes from the primary care doctor)** (*this was mentioned by several participants*)
- ✦ “I’ve been really happy with MMP 1, as far as getting referrals within two weeks. That’s very easy for me to get now or have taken care of now.” (General, Beverly Hills)

- ✚ “It’s because of the referral thing. Before [I had MMP 1] you had to call each whatever and say, ‘Do you accept this?’ This one - they can give you referrals.” (General, Encino)
- ✚ “When I call for referrals, they’re very good about that ... [I call] the number for MMP 1. They’re really good about that.” (General, Encino)
- ✚ “What I appreciate is the referrals...there were times where I needed to go to a specialized doctor for my hearing. They [MMP 2] were able to give me a list of providers I can go to. I was able to go and get an appointment I remember fairly quickly.” (General, Encino)

➤ **Good customer service at Member Services** (*this was mentioned by some participants*)

- ✚ “When I call the number [for my plan], the customer service representatives are knowledgeable for the most part...Then if they’re not, they check with someone else...I can make a call 24 hours a day.” (General, Beverly Hills)
- ✚ “I’m really grateful for MMP 1 – their customer service is very good when I call the 800 number.” (General, Encino)
- ✚ “Whenever you want to know something medical, you can call and talk to the triage nurse or anybody on there.” (LTSS, Beverly Hills)

Mentioned in San Francisco Spanish-language groups

➤ **Access to Spanish-speaking plan representatives and providers** (*this was mentioned by several participants*)

- ✚ “The good thing is that they ask you before if you want it in Spanish or in English, and they send [providers] in the language that you want.” (Spanish Language, San Francisco)
- ✚ “[The plan] calls me, and they call me in Spanish. I’m telling you, they have service in Spanish.” (Spanish Language, San Francisco)

Factors that diminished satisfaction. The following contributed to low ratings, as well as ratings of 4 instead of 5:

Mentioned in both Los Angeles and San Francisco

➤ **Dental and vision coverage is limited, difficult to use, or has changed (compared to past coverage or since enrolling in the plan)** (*this was mentioned by several participants*)

- ✚ “I’m having real trouble getting a new pair of glasses, and getting my teeth done. I just seem to have lost all the benefits.” (LTSS, Encino)
- ✚ “[My plan] doesn’t offer contacts, only glasses...I primarily wear contacts, and they don’t cover that.” (General, Encino)

- ✦ “My dental with MMP 3 is awful...being denied a lot, having the dentist to submit two or three times before it gets approved.” (General, Encino)
 - ✦ “MMP 2 was supposed to provide dental...a year later MMP 2 dropped the dental part totally and you use Medi-Cal regular.” (LTSS, Beverly Hills)
 - ✦ “Dental coverage used to be better. It’s not the same. I do get my free cleaning every year. It used to be two a year, now it’s one a year.” (General, San Francisco)
 - ✦ “They only cover from the eye tooth in the front...they don’t cover the back stuff [teeth in the back of the mouth], and that’s what costs the most money.” (General, San Francisco)
 - ✦ “What they give us is very little [for glasses]. It’s not enough to cover all of the expenses.” (Spanish Language, San Francisco)
- **Referrals to providers or facilities that provide unsatisfactory care** (*this was mentioned by a few English-language participants*)
- ✦ “Since I’ve been with MMP 1, I’ve probably been with seven or eight different [primary care doctors] ... I changed doctors because I didn’t feel like he was doing, for my body, what needed to be done.” (LTSS, Beverly Hills)
 - ✦ “They’ve been good - other than this one time at this eye clinic that they sent me to...these really young folks. I like to see someone kind of seasoned when they’re coming to mess with my eyes.” (General, Encino)
 - ✦ “Some of the referrals they gave for the optometrist – they gave me a terrible one last year...the optometrist had so many complaints that they lost their license right now.” (General, San Francisco)
- **Administrative and billing issues and errors** (*this was mentioned by some participants*)
- ✦ “They [the plan] gave me a second round of physical therapy, but I got a bill for it, and I wasn’t supposed to have paid – but I got a bill for it.” (General, Beverly Hills)
 - ✦ “I was charged \$250 where I got a colonoscopy. It took me two months - but I got on their cases [at the plan] and I just received my check.” (LTSS, Encino)
 - ✦ “When I got my medical urological supplies, the company will send me a letter [about] my costs – where there was [should be] no copay. Then you keep getting these, and then it says we are going to turn it over to a collection agency and ruin your credit.” (LTSS, Encino)
 - ✦ “They charged me for the ambulance. I was in emergency for two days. I appealed the charges.” (Spanish Language, San Francisco)

- ✚ “I had a bill for \$7,000. I was nervous the whole time when I got the bill.” (Spanish Language, San Francisco)
- **Difficulties with transportation services available through the plan** (*this was mentioned by several participants*)
 - ✚ “I used the MMP 1 transportation one time and they got me to my appointment – picked me up like two hours before my appointment! So, I’m sitting in front of the doctor’s office for two hours. They weren’t even open!” (LTSS, Beverly Hills)
 - ✚ “I have MMP 1...they contracted with them [a dispatcher] for medical transportation. The people can take the order - but they just can’t make it happen...four years ago this was an absolutely wonderful company and you could make an appointment and not worry about it. Now I have to flip a coin whether I’m going to get there or not...They’re horrible.” (LTSS, Beverly Hills)
 - ✚ “There’s really been a lot of waiting. The first time I used it, they were supposed to pick me up at a certain time, and they didn’t show up.” (General, Encino)
 - ✚ “I had to stay on the floor [at the hospital for five or six hours [waiting for transportation] ...I kept calling. They said, ‘They’ll be there in 20 minutes.’” (Spanish Language, San Francisco)
- **Language barriers that impede communication with providers** (*this was mentioned by a few English-speaking participants*)
 - ✚ “The only thing I don’t like with my plan...every doctor they refer me to speaks Farsi...and it’s a big problem for me...After my stroke, I needed transportation to go to my therapy. Number one [problem]. Zero English.” (LTSS, Beverly Hills)
 - ✚ “Not to be rude, but the dentists were Russian, and I don’t understand anything they are saying.” (General, San Francisco)

Mentioned in Los Angeles

- **Provider access issues – including difficulty finding providers who accept the plan and providers not available in or leaving the plan networks** (*this was mentioned by some participants*)
 - ✚ “To find a primary care physician is really almost impossible [with MMP 2].” (LTSS, Beverly Hills)
 - ✚ “[With MMP 2], the hard thing has been trying to get a new doctor...I’m not crazy about the new physician. I’m trying to get the name of somebody, and most of them don’t even speak English. It’s been very, very frustrating. Trying to find a female doctor is hard. It’s very frustrating and exhausting. It takes hours for me.” (General, Encino)

- ✦ “I had a pain management doctor who I loved, and he dropped MMP 2 because they don’t pay promptly.” (LTSS, Beverly Hills)
 - ✦ “I let them [the state] switch me over to these new plans from being on Medi-Cal before...they were promising us the same physicians, and I had some of the best doctors anywhere in the world...and I wasn’t able to get them.” (LTSS, Encino)
 - ✦ “I want a psychiatrist and a therapist and there is none in the Valley.” (LTSS, Encino)
- **Delays in getting needed care or equipment due to requirements** (*this was mentioned by a very few participants*)
- ✦ “I wanted to see an orthopedic doctor...but the health insurance company [MMP 2] goes, ‘No, we turned this down. You have to go through all of this lengthy [physical] therapy first.’” (General, Encino)
 - ✦ “I used to just go directly to my doctor and he would say, ‘Oh, you need a new [wheel]chair’ and write a prescription...But this time I had to go through three specialists [before I got it.]...it was totally unnecessary, and it took so long when I needed things right away.” (LTSS, Encino)

Mentioned in San Francisco

- **Long wait times for doctor’s appointments** (*this was mentioned by English- language participants*)
- ✦ “You have to see your primary doctor...and she sends you to the hospital [to see a specialist]...It takes a couple of weeks and sometimes a couple of months.” (General, San Francisco)
 - ✦ “They’re booked solid a lot of times...you just have to wait.” (General, San Francisco)
 - ✦ “If you need to see someone new - it took me like three months to finally see a psychiatrist.” (General, San Francisco)
- **Lack of access to Spanish-language providers and the need to rely on interpreters** (*this was mentioned by several Spanish-language participants*)
- ✦ “It kills me when they send me to doctors that don’t speak Spanish...That’s what kills me because then I have to ask for an interpreter to help me.” (Spanish Language, San Francisco)
 - ✦ “The doctor that came to see me [at home], I told them to send me a doctor who speaks Spanish. They sent someone that speaks English with a radio [for translation]...I was lost.” (Spanish Language, San Francisco)
 - ✦ “Sometimes we don’t [use the transportation services] because they send a taxi driver who doesn’t speak Spanish.” (Spanish Language, San Francisco)

CARE COORDINATION IN CAL MEDICONNECT PLAN

For a significant portion of the group time, participants discussed their experiences with care coordination in their Cal MediConnect plans.

Overview of Care Coordination

To begin the discussion, participants were oriented to the concept of care coordination as follows: *When you have multiple health needs and providers, it's important to make sure your care from all different sources is organized and that everyone involved is "on the same page" - so that your needs are being met and you are getting the care you need, when you need it. This is called care coordination. You might have someone in your life – or even more than one person - who works with you and your providers to make sure this kind of coordination is happening.*

Then, they were asked to describe who in their lives helps them accomplish this care coordination.

Across all groups, participants described a mix of influences on their overall care coordination, which are discussed below. Most notably, they identified influences from their personal lives (themselves, family members), health care providers (usually their primary care physicians), and, to varying extents, their Cal MediConnect plans.

Personal influences. Across all groups, participants usually played an important and primary role in their own care coordination. However, some, especially in the Spanish-language groups, also relied heavily on assistance from family members.

- **Self.** Virtually all participants did at least some of their care coordination on their own, such as communicating with their doctors, making appointments, and arranging for transportation (including from the services provided by the plan).
 - However, English-language participants had the most confidence in their ability to oversee their care. There were frequent comments about the need to “stay on top of” and “be proactive” about one’s own care. As one participant emphasized, “We are able to make decisions and understand what is going on” (General, Encino). Participants self-managed their care because they were able to, it was practical (e.g., they made appointments that suited their lives and schedules), and for a few, because it seemed easier than involving potentially complicating third parties (such as dedicated care coordinators from their plans) into their care situation.
 - While relatively independent overall, Spanish-language participants seemed to need more support in managing their care, due to their lack of familiarity with how insurance and the health care system works and language barriers. They needed help to understand and navigate the system, including from family and from any other supportive influences in their lives, such as care coordinators, social workers, and health care providers.

- **Family members.** A few English- and many Spanish-language participants worked closely with family members to manage their care.
 - In the English-language groups, a few participants with more intensive needs (particularly LTSS but also a few General beneficiaries) had family members who helped them organize (or who they occasionally consulted about) their care – either their adult children or their spouses/partners. It was difficult to tell for sure, but when these participants also had care coordinators from their plans, their family members did not seem to communicate with them. When participants were not especially close to care coordinators, which was usually the case across groups, there was not much opportunity for family members to interact with them. In a very few cases, LTSS participants had family members who were also their In-Home Supportive Services (IHSS) providers, and these individuals were very involved their care.
 - In the Spanish-language groups, many participants had help from at least one and sometimes multiple family members. One described his support network as follows, “My wife helps me. My daughters, my sons-in-law. I have plenty of people that can help me.” (Spanish-Language, San Francisco). In particular, their children helped them to navigate the plan and the health system in general, sometimes took them to appointments, and sometimes spoke to doctors or answered calls from their plans on their behalf.

However, it is worth noting that in the English-language groups, a number of participants seemed to lack family support. In some cases, they were overseeing their own care and relying on outside help, including from their plans, as a result of this. Either they did not have family that lived locally, or they did but they were not readily available. For example, one participant who had just connected with a new care coordinator from her plan and said, “I need someone to help me...My kids - I have five – but they are all into their own lives” (General, Encino).

Primary care providers. Across all groups, participants very often mentioned that their doctors or nurse practitioners were involved in coordinating their care. Even if they had care coordinators from their plans, they still talked to their doctors when they had questions or needs and responded to their doctor’s instructions.

- About a quarter of all English-language participants considered their primary care doctors (or, in a very few cases, a nurse practitioner) to be the main coordinators of their care. When asked who helped them to organize their care, selected responses included, “I have good access to my general practitioner – I call and leave a message for her to say, ‘I need X, Y and Z - and it is handled quickly and efficiently’” (General, San Francisco) and “I have a nurse practitioner – she coordinates everything, she knows everything about my history” (General, Encino).

It was not clear if this was the case because a care coordination role had been delegated to their doctor by the plan, or if it was the pre-existing nature of that doctor-patient relationship. Nonetheless, for a few, it was their preference, and as one participant commented, “My doctor is directly who I go to. People from MMP 2 have called to be my care coordinator – but I haven’t had them” (LTSS, Encino).

- While Spanish-language participants viewed their doctors positively and as very important, it was unclear if any considered their doctor to be their main care coordinator. In an exception to this, one participant seemed to – as he said, “I go pretty much straight to the doctor [not the plan]. I don’t have to make an appointment with him. That’s my primary doctor” (Spanish Language, San Francisco). Although they were positive about their doctors, they did not articulate the close working relationships with them that some in the English-language groups did. For some, this might have been due to language barriers and the distance created by using an interpreter in a medical setting. For example, one said, “I’ve used a lot of interpreters...My doctor used to speak Spanish, and she was great...then, now, they assigned me a Chinese doctor” (Spanish Language, San Francisco).

Cal MediConnect care coordinator. Participants were asked if they had been assigned a care coordinator (or care navigator or case manager) since enrolling in their Cal MediConnect plans.

Many in Los Angeles said that they had been assigned or at least contacted by a care coordinator after their plan enrollment, while some San Francisco participants (English and Spanish-language) described this. However, this was not a guarantee that participants had developed or maintained a relationship with one. In fact, a number who had been assigned a care coordinator did not seem to be working with that person now. Participants’ current care coordinator status, as it was evident during the groups, is summarized below:

- In the six Los Angeles groups, roughly half of all participants currently had what they considered to be a dedicated care coordinator from their plan. When referring to this person, they almost always used the term *care coordinator*, not *care navigator* or *case manager*. This was someone who they could specifically identify as a care coordinator and for whom, in most cases, they had a direct phone number.
- In the two San Francisco English-language groups, only one or two participants thought they had a dedicated care coordinator from their plan, and they did not work closely with this person. A few referred to behavioral health case managers. In addition, a few had declined a care coordinator when it was offered by the plan. The rest got help in other ways, including directly from their doctors, from a coordinator based at a provider group (in one cases), by calling Member Services. Participants in these groups did not seem to be familiar with or use the term *care navigator*.
- In the two San Francisco Spanish-language groups, it was very difficult to tell for sure how many participants had dedicated care coordinators, because they were often unsure of this

themselves. However, when probed, a few felt fairly certain that they did have someone from the plan who occupied this role – the majority used the term *care coordinator*, or in a few cases, *care navigator*. As one said, “[First name] is the navigator. The navigator sends you information to find out what you need and who to call” (Spanish Language, San Francisco).

While the presence of a dedicated care coordinator or navigator was hard to discern, it is important to note a number of Spanish-language participants did talk about hearing from variety of helping influences they believed to be relevant to their plans – besides care coordinators, they often mentioned their social workers, nurses, and the health care providers who, in some cases, came to their homes.

Of those participants who had dedicated care coordinators from their plans, those with more intensive needs (including some LTSS and General beneficiaries) were the most familiar with their care coordinators, and in some cases had personal relationships with them. Selected participant comments that illustrated this included the following:

- ✚ “[First name] calls me up and we talk about a lot of things...sometimes it just throws me off and then I’m overwhelmed with a lot of doctor’s appointments...and she has calmed me down a lot. She comes from MMP 1.” (LTSS, Beverly Hills)
- ✚ “She [first name] calls me every month to see if I need anything and appointments and all that. Because I’ve had two heart attacks and a stroke.” (LTSS, Encino)
- ✚ “[First name]. I don’t know her last name, but she calls me all the time.” (General, Encino)
- ✚ “The person that coordinates, I have her name. Her name is [first and last name].” (Spanish Language, San Francisco)

For those with fewer needs, care coordinators tended to be “in the background” - unless they needed something or a significant health event occurred. For example, one participant who was in this situation said, “I don’t have any needs at this time, but I have her number. She is there.” (LTSS, Beverly Hills). It consisted mostly of 1) regular or semi-regular check-in calls from the coordinator and 2) contact originated by the beneficiary if they had a particular need or question.

Care coordinator via provider group. A few participants in Los Angeles and one in San Francisco had care coordinators who were based in their provider groups. They seemed to rely on these first for help, more so than anyone directly from their plans. For example, one participant said, “My case person from Medical Group 1 calls me just to follow up and see how I am doing.” (General, Encino). These participants generally knew that there are relationships between provider groups and Cal MediConnect plans. However, they did not seem to be specifically aware of any delegation of care coordination to their provider groups. For example, one said, “I am confused if I have a case manager through them [my plan] because he actually belongs to a medical group called Medical Group 2” (General, Beverly Hills).

There were very few Spanish-language participants - and one English-language participant - in San Francisco who felt they were getting care coordination services from a medical provider group (Landmark). As one participant said, “I know the ladies’ names [from Landmark]...and they will give me specific answers according to my plan...I call them, and I say, ‘What will I need to do in order to do this specific thing?’” (General, San Francisco).

As an aside, a few participants also mentioned that they valued the communication and coordination made possible by the electronic health record systems that had been implemented in provider groups. For example, one participant said, “Medical Group 3, they give you referrals. Everybody is on the same network, so everyone knows what everyone is doing. That’s what I like about them. You can go to your medical doctor, your pain specialist, and whatever, and everybody is on the same line...reading the same notes” (General, Encino).

Cal MediConnect plan member services. In the English-language groups, virtually all participants knew that they could contact their plans via the Member Services phone number on the back of their cards. (Several also mentioned occasionally using the other numbers on their cards as needed, such as for an advice nurse and mental health services.)

- When participants did not work with a dedicated care coordinator (or had a distant relationship with theirs), calling Member Services was an essential and often primary approach to communicating with their plans. This was particularly true in San Francisco, where again, most participants said they did not have a dedicated care coordinator from their plan. For example, as one San Francisco participant commented, “I know that I don’t have a specific care coordinator...You call Member Services” (General, San Francisco).
- Several in Los Angeles also did this – it seemed to be a default solution for some, who said that whenever they had a question or problem, “I call Member Services” and “I just call the number on the back of my card.”
- In general, most participants were positive about their experiences calling Member Services. As one said, “They’re always very responsive whenever I call the 800 number for MMP 1” (General, Encino). However, in San Francisco, a very few participants were frustrated by having to work with someone different every time they called Member Services. As one said, “They need to have care coordinators assigned...have a care coordinator over a group of people [members] and have those patient’s records...a coordinator that you can call” (General, San Francisco).

In the Spanish-language groups, participants did not mention calling Member Services, specifically. While some did describe calling a particular contact they knew (like a care coordinator), overall, most did not seem to originate contact with their plans very often. More often, they described being proactively contacted by plan representatives.

General contact from Cal MediConnect plan. Across all English- and Spanish-language groups, even if participants did not feel they had a dedicated care coordinator, most participants did describe being contacted by plan representatives on a somewhat regular basis. It was clear that for most, their health plan was a part of their lives. Participants in both Los Angeles and San Francisco were contacted by their plans, although very generally it seemed that English-language Los Angeles participants had more interactions with their plans than did those in San Francisco.

According to participants, the purpose of these plan-originated calls varied but included the following: a needs assessment questionnaire (administered annually or semiannually) during which available services were mentioned or offered, patient satisfaction surveys (such as to rate experiences with doctors), medication management, and reminders to get preventive health care. Several participants also mentioned getting reminders from their plans about preventive health (e.g., mammograms, colonoscopies) in the mail.

Participants who were not connected to a dedicated care coordinator often referred to the representatives who called only generally as “someone” or “somebody.” It was difficult to tell if participants were, in fact, being contacted by care coordinators – because they did not know this for sure themselves. Moreover, they did describe a personal connection or continuity with one person from the plan, instead they seemed to be hearing from different people. For some, it was generally hard to differentiate who was calling them, especially if they were getting support and contacts from multiple health care providers and organizations.

More generally, some had difficulty differentiating among the various telephone contacts they experienced - especially if they were also getting support from other sources - such as from social workers, behavioral health services, IHSS, their doctors, or community organizations. As one participant commented to this effect, “I don’t know who is coming from where...Over the last couple of years, there seems to be so many people wanting to help. So much information. So many calls” (LTSS, Encino). This was particularly the case for Spanish-language participants, who were frequently already confused about how their plans and the health care system worked, were dealing with language barriers, and were sometimes suspicious of calls (from their plans or anyone) that seemed to be offering them help or services (due to fears about fraud).

Other care coordination influences. In a few cases, participants mentioned other professionals who they viewed as involved in the coordination of their overall care.

- **Social workers.** A few in Los Angeles and several in San Francisco (particularly among Spanish-language participants) said they had social workers who helped them with care coordination. They seemed to regard these social workers as essentially the same thing as a care coordinator and as somehow affiliated with their plans.
- **Behavioral health case managers.** In San Francisco (as previously noted) and Los Angeles, a few English-language participants had case managers for behavioral health services they were receiving. They seemed to rely on this person for help with their care, but this seemed

to be focused primarily on their mental health care, not other general health needs. As one said, “I’m calling my case manager through behavioral health - because he is the one that kind of helps me the most” (General, San Francisco).

Barriers to having a care coordinator. As previously noted, there were a number of participants who did not report currently working with a dedicated care coordinator from their plans. Even if they had been assigned one at the beginning of their plan enrollment (as many in the English-language groups recalled they had), the relationship did not always develop into an ongoing one. Reasons for this included the following:

- **Lack of receptivity to care coordinators.** Across groups, a few English-language participants had been offered the help of a care coordinator by their plan, but they had expressly declined it in favor of managing their care on their own or with their doctors. A very few resisted care coordinators because they felt they would only add complexity (e.g., “more layers”) to their situations. Selected comments regarding declining care coordinators included the following:
 - ✚ “They offered [a care coordinator], but I didn’t take it.” (General, Encino)
 - ✚ “I don’t have someone that organizes it, but I’ve had calls from MMP 1 where they want to organize it.” (General, Encino)
 - ✚ “I am able to coordinate my own things. When they call, they want it to become official, and to visit or whatever. I don’t want that.” (LTSS, Encino)
 - ✚ “I’ve gotten a letter a couple of times over the past two years saying that...I don’t know if it’s coming from the MMP 5, Medicare, or Medi-Cal – but they’re saying they would provide you with a health care coordinator to help you stay on track with your appointments. They would work with you on medications and stuff. I felt like I don’t need one more person in the mix trying to organize my life when I’ve got it finally to a point where I can make things happen. I know who to talk to....I just don’t know if I want one more person dabbling in it who I don’t know” (General, San Francisco).
- **Difficulty connecting with/lack of access to care coordinators.** Some participants seemed to have struggled to connect with a care coordinator from their plan or through their provider groups.
 - Some English-language participants had experienced this and attributed it to communication problems (such as unsuccessful contact attempts by the plan or lapses in contact from the care coordinator), turnover or personnel changes that left them “in between” care coordinators, or just the overall sense of “falling through the cracks” of the system. Illustrative comments included the following:

- ✚ “I have one [a care coordinator] - but the problem is, I haven’t been in contact with them in so long that I don’t know who they are anymore.” (LTSS, Beverly Hills)
- ✚ “When I first signed up, somebody called me and said they were my nurse practitioner...she was going to hook me up with all kinds of stuff...I tried calling her about a month later she didn’t work there anymore. They never assigned me another one.” (General, Encino)
- ✚ “I have nothing to say about care coordination because I have never met any of them or managed to do anything via them.” (LTSS, Beverly Hills)
- ✚ “I think I have a couple of them. They seem to go into the woodwork. And then I never hear from them again.” (LTSS, Beverly Hills)
- ✚ “I tried to get one - but I don’t know how to get one...I’ve tried to figure out how to get somebody like that, and I can’t find one. Or there’s been people who call themselves case managers who don’t really help me.” (General, San Francisco)
- Some Spanish-language participants were unfamiliar with the concept of a care coordinator (or navigator) and did not know if they had one or that it could be available. Comments to this effect included the following:
 - ✚ “I never knew anything about a coordinator. I don’t have a phone. Nobody calls me. So, I don’t know.” (Spanish Language, San Francisco)
 - ✚ “I don’t have a navigator. I wish I had a navigator.” (Spanish Language, San Francisco)
 - ✚ “We don’t know if we have a [care coordinator].” (Spanish Language, San Francisco)
- **Skepticism about initial care coordinator contacts.** Both English- and Spanish-language participants described suspicion and fear of the unknown as a potential barrier to accepting care coordinator’s assistance. Even if participants ultimately ended up working with a care coordinator, this was disruptive to the onboarding process.
 - Several English-language participants were surprised at first to be contacted by a care coordinator, they had not expected the call. As they frequently described it, “someone just called me” without prior notice. Because they were unsure of who was calling, a few had contacted their doctor or the plan for verification of the person’s legitimacy. If the person was unknown to the doctor’s office, this was unsettling to participants. For example, one participant said, “I never knew I had a care coordinator. Then I got a call from someone who said they wanted to come see me at my house. I thought they were going to serve me! When I asked the physician about this, like ‘Do I need to see this person’ – they had no idea who it was” (Encino, General).

- Some Spanish-language participants noted that they (and, the Latino community in general, in their view) are wary of contact from unknown callers, especially those who offer them services. This is due to what they described as prevalent fraud in the Latino community, especially as inflicted by people who take advantage of their language vulnerabilities. As one participant described, “The problem we have, we Latinos, is that we don’t speak English...we get calls in English and we don’t understand...we’re very skeptical about believing anyone because sometimes they cheat us. I know a lot of people who have been cheated or lied to” (Spanish Language, San Francisco). This skepticism seemed to be a barrier for some to accepting care coordinator calls.

Additional Care Coordination Topics

Participants discussed the role of care coordinators in greater depth. Again, some but not all felt they were working with a dedicated care coordinator from their plan.

Definition of care coordinator. To further orient participants to the concept, the moderator presented them with the following definition of care coordinator: *A Care Coordinator (or Navigator, Case Manager) could be a trained health professional or a family member or friend who helps manage your care. For example, they help coordinate your care, connect you with PCPs or specialists, educate you about your condition, or arrange other services you might need, such as transportation.*

- Among English-language participants, this definition resonated most with those higher-need participants who had very involved care coordinators. Those whose care coordinators were more of a background resource (or who did much of their own care coordination) felt that the definition, while perhaps accurate, was less relevant to them since they had not needed or availed themselves of the kinds of help described in it. For those without care coordinators, the definition was not directly relevant, but it did seem to remind them that, despite lacking a dedicated care coordinator, they had been offered help and services by their plans (such as during annual needs assessment calls).
- Among Spanish-language participants, the definition evoked comments about the variety of help participants were receiving, including from social workers and health care providers who came to their homes. Again, only a few seemed to know with any certainty that they had a care coordinator (or care navigator).

Expectations for care coordinators. Participants in a few English-language groups were asked if they had expectations of care coordinators when they were first assigned one. Consistently they said they had not known what to expect. Again, some had been surprised when they were contacted by one.

Some said that, after some time, they had been pleasantly surprised by the attention and care they had received from care coordinators. For example, one said “With me, there was very much a

surprise of the caring they gave me...They were so caring, and they were so informed of different areas they could do for you” (General, Encino). However, in contrast, some (particularly in Los Angeles) had experienced care coordinator turnover or lapses in contact – as a result they were underwhelmed by their care coordinator experiences so far.

Frequency of care coordination contact. Participants were asked about how frequently they were contacted by care coordinators (or, if they did not have a care coordinator, by their plans).

- **Contact from “the plan” - i.e., plan representatives.** Across all groups, most participants had received an initial call from the plan, the purpose of which was to assess their needs and, in some cases, to pair them with a care coordinator if necessary. For example, one participant described this initial call as follows: “It was like a screening, and the screening process took maybe 15 to 20 minutes. They just asked a lot of questions about my abilities, my health, and if I needed someone to coordinate my care...That was from the plan itself” (General, Encino). Said another, “They just tell you that they are calling from MMP 5....and they do all of the questions” (Spanish Language, San Francisco).

After this initial assessment, participants across all groups reported being contacted with a needs assessment questionnaire - usually either annually or semiannually. This seemed to be a critical way that their needs were identified, and a key element of making beneficiaries aware of what services are available to them through Cal MediConnect. According to some, plan representatives used this call as an opportunity to mention plan benefits and services that could be of help to them.

Some who did not feel they had care coordinators also described getting additional calls from the plan to ask about their needs – even without a dedicated person, they seemed to be receiving “check-ins” from “someone” at the plan. As one participant described this, “I get a call once a quarter...They’ll make service suggestions or ask if I need certain things. They said, ‘Do you need in-home care? Do you need transportation? Do you need a coordinator?’ I always say no to those things because I don’t need them, but they do make them available” (General, Encino).

Many also reported being contacted fairly often by their plans to take patient satisfaction surveys – such as to rate their health care providers, as well as to rate their overall experiences with the plan. As one said, “They ask you what is the rating of the service, how good is the service that they give you at the clinic, if everything is adequate to you.” (Spanish-Language, San Francisco). Usually, they were receptive to these calls (although a few found them bothersome), and some appreciated being asked for their input. However, Some Spanish-language participants mentioned concerns that, if they did not give positive ratings on these surveys, their benefits might be negatively impacted or even lost as a result.

- **Contact from care coordinators.** Participants who had care coordinators mainly communicated with them by phone, although some in the English-language groups reported that they had also been visited (usually just once) by a care coordinator in their homes.
 - In English-language groups, most heard from their care coordinators relatively regularly, either monthly, every two or three months, or quarterly. A few participants who had more acute needs (especially in the LTSS segment) were contacted more often – typically multiple times a month and even every few days by phone (such as if they were in the midst of an acute life or health situation). They were usually comfortable with the amount of contact they currently received from their care coordinators, and they liked it when care coordinators proactively contacted them. Even if they did not need much assistance now, they liked knowing that their help was available and “an option.” As one participant said of monthly calls from a care coordinator, “I’ll take all the help I can get” (General, Encino).
 - Those few Spanish-language participants who had care coordinators did not specify how often they heard from them, but their comments implied fairly regular contact. For example, one said of his care coordinator, “They call me...they ask me if I took my medication. They ask me all kinds of things. They help me.”
- Some English-language participants wanted more contact with their care coordinators. In contrast, a few others were not reliably receptive to the care coordinators’ contact attempts.
 - A few commented negatively that they had experienced a decline in contact - either due to the care coordinators’ inattentiveness or turnover in the role. For example, one participant said, “I don’t know their names [my care coordinators] because they keep changing. And they were really on top of me for a while...and then she was replaced with someone else, and she was replaced with someone else...I haven’t heard from [her] in a really long time” (LTSS, Encino).

A very few said they only heard from a care coordinator yearly or maybe twice a year, which was not enough. As one said, “I wish they would call me and just find out how I am doing, if I need anything. That would be really nice” (LTSS, Beverly Hills).
 - A few participants mentioned sometimes avoiding or not returning care coordinator calls. As one said of her care coordinator, “At least once a month, they call. But I don’t call back. I feel bad. It’s almost like, if you need something, you call” (General, Encino).

Home visits. Participants also discussed their attitudes about and experiences with home visits since enrolling in their plans.

- **Care coordinator home visits.** Very generally speaking, home visits did not seem to be regular or expected aspect of the beneficiary-care coordinator relationship. However, some English-language participants did report being visited by what they identified as a care

coordinator, either for an initial needs assessment after enrollment or during an acute health event. (The Spanish-language participants who had care coordinators did not mention being visited at home – or they did not clearly articulate this). Participant comments included the following:

- ✚ “She just asked me some questions, like am I able to take care of myself, can I dress myself, can I feed myself? Do I want to get in-home support?” (General, Encino)
- ✚ “He asked me about my health, asked me what kind of medication I take.” (LTSS, Beverly Hills).
- ✚ “After the first stroke, she [my care coordinator] was in my house every week” (LTSS, Beverly Hills)

It is worth noting that some participants had received home visits, but they were not sure if the person visiting them at home was a care coordinator or a different plan representative – i.e., they referred to that person as “someone” or “somebody.”

- ✚ “I did have somebody through MMP 5...They came and visited. [They asked] ‘is everything alright?’ They’re just checking everything.” (General, San Francisco)
- ✚ “On two different occasions, they [someone from the plan] came out and just did a short questionnaire with me to determine if I needed someone to come [help me].” (General, Beverly Hills)

Overall, participants were usually positive about home visits from their plan, which they saw as personal and supportive – e.g., “It does show they are trying to care.” (LTSS, Beverly Hills)

However, some had been offered a home visit by a care coordinator (or other plan representative) but declined it. Reasons for this included their belief that it was unnecessary (e.g., they did not need it), a preference for not having visitors, or concerns about the atmosphere or condition of their home (e.g., presence of pets, disarray, or roommates, etc.). One female participant also said that as a single woman, she was leery of having someone come into her home.

- **Home visits from other professionals.** Across groups, several English- and Spanish-language participants had received home visits from a variety of other professionals with an interest in their care, including social workers and health care providers (who did in-home exams, drew blood, etc.). They assumed these visits were facilitated by their plans (and in some cases, by their care coordinators, specifically), but they were not always sure of this.

Some English- and Spanish-language participants were especially positive about receiving in-home medical care, such as an annual physical, in the home; they found this to be

personal, supportive, and convenient. However, a few disliked this – they found it unnecessary (because they were capable of going to the doctor’s office) or invasive.

All participants preferred that home visits were scheduled by appointment, at their convenience. English-language participants also expected visitors to be prompt and to notify them if they were running late (e.g., due to traffic). As one participant mentioned, “The disadvantage [of home visits] is they cannot really give you a time. It depends on traffic. It depends on a lot of things...It would be nice if they said, ‘I am leaving my last person, I am on the way to see you’ - but some of them do not do that” (LTSS, Beverly Hills). In addition, one participant had been visited unexpectedly by a plan representative at home, which was a strong negative – “I had no idea they were coming by, and they just showed up!” (General, Encino).

Role of Care Coordinator

Participants who had care coordinators (directly from their Cal MediConnect plan or via their provider groups) discussed how these professionals had supported them and what they had done on their behalf since their enrollment in a Cal MediConnect plan. (Again, this was roughly half of all participants queried and therefore usually only a few to some participants in every group.)

First, they were asked generally how their care coordinators helped them. Then specific areas of potential assistance were explored, some of which were supplied by the moderator and others of which naturally emerged from the discussion.

Overall. Across groups and on a top-of-mind basis, participants who had care coordinators most often identified the following ways in which they provided support:

- Assessing initial (at time of enrollment) needs and ongoing needs
- Regular or semi-regular check-in calls (by phone)
- Helping with medication management
- Helping get doctors’ appointments scheduled sooner if needed
- Finding doctors and service providers who accept the plan
- Providing support and getting needs met during care transitions
- Providing general moral support and encouragement

Specific areas of care coordinator assistance were explored in further depth. There was not very extensive discussion regarding any of these topics, again because of the roughly half who had care coordinators, only about half of those had very involved ones.

- **Appointments.** Across all groups, most participants seemed to make their own doctors’ appointments – and many wanted or expected to do this because they valued having control over their own time. For example, one said, “Once they [the plan] give you the referral, they

give you the name, the number, the address, then you call and make an appointment with them directly” (General, Encino).

- A few higher-need LTSS and General beneficiaries reported that their care coordinators had called providers for appointments on their behalf (or had offered to do so). Across groups, a few reported that their care coordinators had been able to expedite provider appointments (which they would not have been able to do themselves) – this kind of help was especially valuable to them.
- A very few Spanish-language participants seemed to be getting help from someone they identified as a care coordinator to set up medical appointments. As one said of this person, “She makes my appointments.” Again, more generally, some Spanish-language participants seemed to need extra help (such as from their children) with making phone calls to doctors and plans – and with navigating the health care system in general - especially if they were not fluent in English.

Across all groups, participants were asked if care coordinators had accompanied them on doctor’s visits. None reported having this experience, and they did not seem to expect it. However, a very few English-language participants said this option had been offered to them. Only a very few English-speaking participants, again typically those with more intensive needs who worked very closely with a care coordinator, reported that their care coordinators had ever called them to follow-up after their doctor visits.

➤ **In-home services.** English-and Spanish-language General participants discussed their awareness and experiences with in-home services through their plans. [Many LTSS participants were receiving In-Home Supportive Services (IHSS) – their experiences with these are discussed in a separate section of this report on page 53.]

- With a very few exceptions in San Francisco, English-language General beneficiaries did not report currently using any in-home services, although many were aware that this kind of help was available to them. A few mentioned that they had qualified for (but declined) them. For example, one said, “I was offered it, but I ended up turning it down” (General, San Francisco). One General beneficiary was in the process of getting in-home services set up now (with the help of his care coordinator).

Most often, participants in Los Angeles and San Francisco seemed to have heard about in-home services when the plan administered its annual or semiannual needs assessment questionnaire. As one described it, “It’s through the survey that they discover our needs and wants” (General, Beverly Hills). Said another, “If I responded affirmatively [regarding needing in-home services] - I feel like they would tell me what I needed to know to carry it through” (General, Beverly Hills). In addition, some in Los Angeles had also been asked if they needed in-home services by their care coordinators.

In both markets, a few General participants were independently knowledgeable about IHSS (separate from any plan influence) and recognized that they could get IHSS from “the county.”

- Some Spanish-language participants noted that they had been offered in-home services by a care coordinator or someone else they perceived as related to their plan. As one said, “They ask you if you need a person at home to help you out, to take a shower...they ask you all of those things” (Spanish Language).

A few had declined this so far, either because they did not want to accept help (sometimes due to personal pride), because they felt others needed it more, or because they had family assistance. As one said, “They’ve offered me all of those services even cooking, helping me with shower, and maybe clean the house and vacuum. [I say no.] I’m a Latino. Even if I can’t walk, I can do it. That is how it is. That’s Latino pride.” (Spanish Language, San Francisco). Said another, “They tell me this is what I qualified for...I tell them my wife cooks and takes care of the house” (Spanish Language, San Francisco).

However, a few had accepted in-home services - e.g., “I have a person who comes every day for half an hour, Monday through Friday. They help with me with everything” (Spanish Language, San Francisco).

After hearing others in the group discuss in-home services they used, a few Spanish-language participants were surprised to hear about them. They felt that they would qualify for these based on their health but did not know how to access them. As one said, “I didn’t know about these services. I do need them. I need help urgently...my wife is the same age [as me], she has arthritis and she can’t even touch something because her hands hurt a lot. Sometimes, she has to do the house chores. I didn’t know they had this kind of [in-home services]” (Spanish Language, San Francisco).

- **Care transitions.** Only a very few General English-language participants reported experiencing inpatient stays at the hospital since enrollment in their Cal MediConnect plan, and there was not extensive discussion regarding this topic. However, they made a few positive plan-related comments about the experience, including the following:
 - ✚ “They [my plan] tried to coordinate with my discharge instructions to see if I was doing everything I was supposed to do.” (General, San Francisco)
 - ✚ “You have someone who will set you up with a plan for after-care. It was helpful.” (General, Encino)
 - ✚ “They helped me get medical supplies.” (General, Encino)

Participants with care transition experiences seemed to perceive that their doctors or the hospital had been more involved with their discharge than anyone from their plans – as one said, “the hospital people” organized their transition.

There was not much discussion of the care transition topic in the Spanish-language groups. One or two mentioned that they had care coordinator help after a hospital stay, including one who said that, after her surgery, her daughter had “become friends” with her care coordinator because they had talked so often. The care coordination helped with getting medications and setting up follow-up appointments with specialists.

- **Communication/coordination with non-medical service providers.** Participants often reported needing services and care that went beyond what their doctors provided - such as dental and vision care or medical supplies. Care coordinators did not seem to play a significant role for most in this area, unless they were higher-need or had an acute care need (such as arranging for medical supplies after a hospital stay). Among English-language participants, one participant communicated a prevalent sentiment about this as follows, “I do everything myself” (LTSS, Beverly Hills). Said another when asked if anyone contacted service providers on her behalf, “Are you kidding? Unless you are not able to do it [contact service providers] yourself, they give you the dignity of caring for yourself” (General, San Francisco).

Some Spanish-language participants seemed to rely on family help (usually their children) – or in a few cases care coordinators – for communicating with these providers. They seemed to lack the confidence to “reach out” to specific providers on their own. However, some did mention making their own calls to dentists, for glasses, and to schedule transportation providers.

- **Patient education.** Participants were asked if their care coordinators provided them with education regarding their chronic conditions or other aspects of healthy living. There was not extensive discussion of this. Participants usually felt that they got the most education about their health and health conditions from their doctors – more so than from care coordinators. However, English-language participants did report receiving a variety of educational communications directly from the plan, such as newsletters (that had both health and practical information such as contact numbers in it) and information and reminders in the mail about preventive health (e.g. mammograms, colonoscopies, etc.), as well as smoking cessation, high blood pressure, diabetes, and diet and nutrition. They said these were somewhat helpful, although a very few found the information too elementary in tone (i.e. “we already know it all”). A very few mentioned that they received communications from the plan regarding updates to dental and vision coverage and that this was valuable to them.

A few Spanish-language participants commented generally that the plan sends a “lot of paperwork” and that it is often “confusing.” It was not clear what kinds of materials they

were referring to, but they expressed a desire for Spanish-language communications written at a level that was easy to understand. Spanish-language participants, in general, many of whom were lower education, expressed dislike of having to read a lot of information, especially related to their health care and insurance. However, a few did mention that they had noticed and used some printed information, such brochures about transportation services.

- **Medication management.** A few English- and Spanish-language participants mentioned that their care coordinators helped them oversee their medications. Their care coordinators became familiar with their medications, inquired about them over the phone, and reviewed them if they came to their homes. In San Francisco, one General participant (who viewed her doctor as her care coordinator) said that a plan representative also contacted her semiannually to review her medications with her.

Medication oversight, if not provided directly by care coordinators, seemed to be integrated into other touchpoints (that were likely facilitated by care coordinators or someone else at the plan), such as in-home medical care. For example, one participant commented, “The doctor came to my house...and he asked me to show him all the medication” (Spanish Language, San Francisco).

In a few cases, care coordinators also helped participants to get prescriptions refilled and resolve disputes about medication coverage. It was particularly valuable to participants when the care coordinator intervened when a medication was not paid for by the plan (either by contacting the doctor or pharmacy to resolve the issue or obtaining a prior authorization for the drug if needed).

However, a few Spanish-language participants seemed to have needed help with medication coverage problems but not known how to get it. They seemed to accept the situation without realizing that they could call someone at the plan for assistance. For example, one said, “What happens is that you get to the pharmacy and they call the insurance company, and they tell you the insurance company doesn’t cover it. Then I think to myself, ‘Well, they don’t cover it.’ And then I have to pay” (Spanish Language, San Francisco).

- **Arrangement for nursing or physician care in the home.** Several English- and Spanish-language participants described experiences receiving either skilled nursing or physician care in their homes. Although it was not always clear to them where this originated from, they assumed these providers had been arranged for by their plan (sometimes through provider groups or specifically by their care coordinator) in response to their needs.

In some cases, this in-home medical care occurred on a short-term basis, such as after a hospital or nursing home stay. However, a few English-language and some Spanish-language participant described receiving primary care at home, sometimes on a recurrent basis (e.g., twice a year). Selected comments related to this included the following:

- ✦ “A lady called me, and she said she would like to do a real physical, in home. She came all the way from Laguna...she came up with her little bag and she was with me for about 40 minutes. I think MMP 1 asked her to come.” (General, Beverly Hills)
- ✦ “Once or twice a year, someone comes [to the home] to take your heart rate and things like that.” (General, San Francisco)
- ✦ “The nurse calls me. She comes to my house. She takes my pressure and everything. She makes my appointment for the next time.” (Spanish Language, San Francisco)
- ✦ “I have a nurse that is sent to my house twice a year so they can check me.” (Spanish Language, San Francisco)

Participants seemed to like this personal, convenient approach. For example, one said of a nurse practitioner’s visit, “It’s actually nice. She had all the stuff and everything” (LTSS, Beverly Hills). However, a few English-language participants noted that their care coordinator had offered to have a physician come to their homes, but that they had declined this because they felt able to (and preferred) go to the doctor on their own.

In San Francisco, a few participants in the English and Spanish-language groups specifically had received medical care at home through a medical provider group (Medical Group 4) that provides this for higher-need patients. They had been connected to this group through their health plan, were very positive about it, and seemed to be getting care coordination services through them as well. As one said, “Medical Group 4...they come to your house. I said I was afraid of falling again, and now they send a person to my home. The doctor came, he saw me” (Spanish Language, San Francisco).

- **Connection to community services.** There was not much discussion of this across groups. A few participants in the Los Angeles LTSS groups reported that their care coordinator had linked them to services from organizations in the broader community. Examples of these that were mentioned by individual participants included the following: adult daycare programs in the local area (with opportunities to have meals, social interactions, and enrichment activities), Food Program 1; Food Program 2, and the Religious Organization 1. A few Spanish-language participants said they had been made aware of senior centers where they could go to socialize as well as food pantries (i.e., “centers where they give you free food”). A few said that a care coordinator had provided them with (or mentioned that they had available) “some numbers” related to housing assistance, but overall there seemed to be skepticism that this was something a care coordinator could help them with, given the perceived scarcity of and wait times for affordable housing.
- **Home modifications for safety.** In the English-language General and LTSS groups, a few participants described having equipment such as shower bars and railings installed in their home. This occurred either as a result of the plan’s needs assessment questionnaire or

because their care coordinator had recognized the need. A few also said these kinds of items had been offered to them, but that they had declined them so far.

One participant expressed frustration because, while her care coordinator had quickly procured a shower bar for her when she needed it, no installation had been provided. As she said, “I had the bar within five days...but no way to get it on the wall...It’s still sitting there, and that was two years ago” (LTSS, Beverly Hills).

No Spanish-language participants mentioned getting any home modifications (although they were not asked directly about this during the groups). A few mentioned that they had been asked by someone affiliated with their plan if their bathrooms at home were safe for them (such as if they were determined to be at risk for falling).

- **Emotional support.** A few English-language participants stressed that they valued the encouragement they received from their care coordinators. They liked the fact that their care coordinators were willing to get to know them, listen to their concerns, and become familiar with their personal lives and situations. As one participant commented, ““It is very comforting [to talk to a care coordinator]. Because I have a lack of confidence in my own children’s interest and my own abilities” (General, Encino).

Barriers to Getting Needed Care

During the care coordination discussion, English-language participants were asked if they ever had difficulty getting the health care or services they needed while in their plan. Comments regarding this were relatively limited - but were usually either related to problems getting coverage for dental care, medication, or medical equipment that they needed.

- In some cases, participants asked for and got help from their care coordinators or called Member Services and successfully resolved these issues. As one described this, “I had a problem with medication, CVS stopped covering it. So, I was able to call the [Cal MediConnect] insurance and say, ‘Take care of that’ – and they contacted the doctor and did whatever they had to do to get it fixed” (LTSS, Beverly Hills).
- In a few cases, a care coordinator had not been able to solve a problem, although they had tried to do so. For example, one mentioned that her care coordinator worked hard to get a particular medication for her, but the coverage was simply unavailable. Participants seemed to appreciate care coordinators’ efforts in these situations, even if they were unsuccessful.

Awareness of Available Resources

Participants were asked if, since enrolling in their Cal MediConnect plan, they had been made aware of a lot of resources that were available to them, including some that they would not have otherwise been aware of. Across groups, participants usually did feel that they were alerted to and offered a variety of services – usually more than they had before they joined their plans. This

was especially the case among Los Angeles participants, who seemed to be getting the most contact and reminders from their plans about what was available to them – and where there was a moderate incidence of care coordinators. For example, one participant commented, “Mine [my care coordinator] has [made me more aware of what I can get] – a lot of things I didn’t know I had” (General, Encino).

While English-language participants in San Francisco seemed to be generally well aware of available services, such as dental and vision, they did not speak as effusively about plans reaching out to them or offering services. It is worth noting again that very few had care coordinators from the plan helping them, while more in Los Angeles did (instead they relied on other help, such as from doctors).

Some Spanish-language participants seemed to have a fairly strong understanding of the benefits that were available to them, especially if they had care coordinators or navigators, social workers, or were provided with in-home medical care. However, others seemed to be unaware of their benefits and unsure of how to find out more about them. As one said, “I don’t know who to call.” Upon listening to others in the group talk, they felt that they were not well informed about what might be available to them (especially the availability of care coordinators, and possibly in-home services and in-home health care provider visits).

ASSESSMENT OF NEEDS, CARE GOALS AND CARE PLANS

Participants were asked how their needs had been assessed and identified once they became a member of their Cal MediConnect plan.

Evaluative Questionnaire

Across English and Spanish groups, and as previously mentioned, participants usually recalled completing a plan-administered questionnaire – usually by phone – that assessed their current physical, and seemingly, mental health, as well as any aspect of their home and family situation that affected their overall well-being. They reported completing this needs assessment either every six months or annually. A very few said they had requested to have it mailed to them, so they could finish it on paper.

Participants recognized that the needs assessment questionnaire was an important way for the plans to identify their needs and, if needed, offer them services. They perceived that it was very important to their plans that they complete the questionnaire. It was noted by a few that plans were persistent in their efforts to administer it. As one said, “If I don’t answer [to do the questionnaire], they will call, and call, and call” (General, Beverly Hills). Similarly, a Spanish-language participant said he got repeated requests from his plan to complete his questionnaire after he forgot to send it back to them.

In general, participants accepted this questionnaire as part of the plan’s needs assessment approach and were willing to complete it. Moreover, when the call from the plan came in, this was a time for them to be informed about services they might want. However, a few participants were negative about the length of the survey – e.g., “It’s long and it’s really annoying to me.” (LTSS, Encino) and “You try to hurry them along and you say, ‘I’m good’ for everything” (General, Beverly Hills).

Discussions with Care Coordinators (Or Other Plan Representatives)

In addition to the formal questionnaire, it did seem that care coordinators or other plan representatives were reaching out to English- and Spanish-language participants periodically by phone (and sometimes in person) to find out what their needs were. As one Spanish-language participant said, “They call me to make sure everything is OK with me.”

Participants with dedicated care coordinators, in some cases, described check-in calls during which care coordinators attempted to find out if they had new or different concerns that required services or solutions.

Care Plan

Participants were asked if they had any experiences developing a care plan. To orient participants to this, the moderator gave the following definition of a care plan: *This is a*

personalized, patient-centered plan for how your particular health needs will be addressed by multiple health care and service providers. To create a care plan, you and your Care Coordinator (or Navigator, Case Manager) identify your needs and how to meet them.

Across all groups, the vast majority of participants were not familiar with care plans and did not feel that they had ever created one with anyone from their plan. As a result, questions regarding care plans were frequently not productive. When asked if they had a care plan, and even after additional probing, responses included “I’ve never had that” (General, Encino) and “No. Never” (LTSS, Encino).

However, a few participants across groups did describe some goal setting and accountability (either plan-, doctor- or self-directed), for their behavioral or physical health.

- A very few English-language participants in San Francisco thought they might have some kind of care plan. For example, one who relied on a behavioral health case manager said, “Through my behavioral health, they do a yearly update of your goals. They make you sign for it” (General, San Francisco). Another described creating a plan with her doctor, which outlined her goals and of which she had a copy – “The doctor talks with you – ‘You really need to walk a minimum of an hour a day. Can I get you to commit to that?’” (General, San Francisco). Another said he set health goals (such as lowering blood sugar) with someone from the plan [it was not clear who], who then checked in on progress every six months.
- A few participants in Los Angeles seemed to have experienced an informal care planning process – i.e., they did not have a plan in writing per se, but they had discussed their needs and goals with their care coordinator, possibly made some personal notes about it, and were aware of specific things they were working towards. In a few cases, the care coordinator followed up with them. As one described, “She would call and ask, ‘Did you walk around the block?’” (LTSS, Beverly Hills).
- A few English-language participants stressed that they set their own health goals and tried to reach them – e.g., “I set them myself. But I didn’t talk to nobody over the phone about it.” (LTSS, Beverly Hills)
- A very few Spanish-language participants also described working toward health goals. For example, one said a plan representative (possibly a care coordinator) had helped him set weight loss targets, and then contacted him periodically to check his progress (e.g., “she tells me in three months she is going to call me back”). Another said, “I don’t know who calls me, but she said it was through my plan. I tell her what I eat. She asked me if I walked and I said, ‘Yes, I walk. I take a walk right after lunch’” (Spanish Language, San Francisco).

ADDITIONAL BENEFITS DISCUSSION

Across all groups, participants discussed two additional Cal MediConnect benefits: transportation and Care Plan Options.

Transportation

Overall, having access to transportation services was very important to those participants who no longer drove or who did not have access to a vehicle. It was an essential benefit for some participants, while a number of others did not use it (either they drove or used public transportation).

- Most English- and Spanish-language participants, both users and non-users of transportation services, were aware that their plans offered a transportation benefit. Usually, they knew the plan only covered rides taken to medical appointments and care. In the Spanish-language groups, however, there were a few who were unaware of this benefit and did not know how to access it.
- Participants became aware of the transportation benefit in a mix of ways – either via their own reading and research in plan materials, from a plan representative, or via their dedicated care coordinator. As one described it, “I was told by a [plan] representative as far as the transportation. I saw it in the handbook, also” (General, Beverly Hills). Said another, “They [the transportation services] come in the brochures that you get sometimes with a stamp that says, ‘If you need it, call this number’” (Spanish Language, San Francisco).
- English-language participants were mixed in their awareness of the recent change to unlimited rides. Some knew about this, but many still referred to what they believed was a monthly cap on the number of rides they could get. Spanish-language participants did not discuss this detail.
- In Los Angeles, participants reported having been driven by taxis, Transportation Vendor 1, and vehicles (i.e., single passenger cars and vans) from a variety of independent transport providers. In San Francisco, English- and Spanish-language participants mentioned using taxis, while English-language participants also had ridden with Transportation Vendor 1. Spanish-language participants mentioned using a charter bus that takes them to a local health care clinic.
- A few English-language participants with mobility difficulties said their needs had been adequately addressed with accessible vans or vehicles that accommodated equipment storage (e.g. walkers). This occurred as long as they requested it when they scheduled the service. One participant commented positively that the driver will come to the door and help beneficiaries as needed, such if they have a wheelchair or a cane.

- Across English- and Spanish-language groups, participants described a mix of experiences with transportation services:
 - Many, particularly in the English-language groups, were positive about them. They were pleased that the rides were free, convenient, usually prompt, and provided by a courteous driver. They were especially pleased that many drivers would help them with their medical equipment and help them to and from the door. Only a very few described negative experiences with drivers, including one who said their courteousness could be “hit or miss.”
 - However, some in both Los Angeles and San Francisco had experienced late pickups, no shows, and long wait times to be picked up at the doctor’s office after their appointment was over. They saw this as a serious problem with the benefit, and it made them wary of depending on it. As one said, “I have to spend money now on Uber and Lyft, because I do not have the ability to just miss appointments anymore, because sometimes they do not show up at all... I want to use [the benefit] again, but I have been burned so many times” (LTSS, Beverly Hills). Said another, “They don’t get there on time. Then you get desperate. I think to myself, I would rather take the bus instead of waiting here” (Spanish Language, San Francisco). Lateness seemed to be more of a problem with independent transport providers than with Lyft, although a few had experienced problems with Lyft too.
 - In addition, for some, the need to schedule rides a day or more in advance made the benefit less appealing – as one said, “If you forget to call them, then you don’t have them” (Spanish Language, San Francisco). They wanted more immediate access to transportation to account for times when an acute need arose (such as the need to get to the hospital quickly).
 - Because the plans relied on a dispatch service instead of the Lyft app, a few in San Francisco noted that it was difficult for them to recognize their Lyft drivers when they arrived, (they were not informed, as they would be if using the app, what model of car to expect.). In one case, this caused a participant to miss a ride (she did not see the car and the driver left.)

Care Plan Options

Participants across groups were asked about their awareness of Care Plan Options (CPO). They were oriented to CPO as follows: *Sometimes people need help and services that go a little beyond the regular things their health plan offers. These are services to help enhance care and help people stay in their homes. For example, this might include home improvements, meals delivered to the home, personal care services (help with bathing or clothing), home modifications, help with purchasing groceries, and personal emergency response systems.*

These services are offered in addition to any IHSS you might receive. These services might be called CPO or Care Plan Option Services, but your plan might call them something else. They go a little beyond the regular services you might typically receive from the plan.

No participants were familiar with the term Care Plan Options or the abbreviation CPO. When given some examples of extra services CPO might include (e.g., air conditioning units to keep hot homes safe in the summer, ramp to ease entrance and exit to home), some thought these sounded appealing, but they were not aware of any way to get them from their plans. As one summarized a common view, “I would never think to call MMP 1 for that” (General, Encino).

LTSS DISCUSSION

Participants in the three Los Angeles LTSS groups discussed a few topics that were segment-specific.

In-Home Supportive Services (IHSS)

Most LTSS participants were currently receiving In-home Supportive Services (IHSS, and they seemed to be quite familiar with how the IHSS system worked. In most cases, their IHSS access had preceded their plan enrollment. One participant summarized a common situation as follows, “I have had in-home support for so long - way before I got on the [Cal MediConnect] health plan.” Participants had been receiving IHSS for anywhere from two to more than ten years.

In general, participants did not associate getting IHSS with their Cal MediConnect plans. Instead, they consistently said IHSS was “through the county.” As one said, I have IHSS, but I just go through the social worker at IHSS, the doctor’s office does not have anything to do with it, or my health insurance” (LTSS, Beverly Hills). However, few noted that Cal MediConnect plan representatives (such as during the needs assessment call) had mentioned IHSS to them – e.g. “They did ask, but I told them I already knew about it and was on it” (LTSS, Beverly Hills).

A very few participants had accessed IHSS after plan enrollment - but they were not sure exactly how this had happened. For example, when one participant was asked how he got connected with IHSS, he said, “I have no idea...I don’t know who is coming from where (LTSS, Encino). Another was more specific in her recollection and said, “I had been in a nursing home, so that’s when MMP 2 brought in a social worker to help set it up” (LTSS, Encino).

Across groups, participants received IHSS that included cooking, cleaning, shopping, and housekeeping assistance through IHSS. If they felt they needed more hours, they either waited for their next IHSS assessment (which occurred yearly) or talked to a social worker with IHSS at the county directly. They did not work with a care coordinator or anyone from their plan for this.

Participants were usually quite positive about IHSS and the help that was provided for them. They expressed gratitude and relief for having access to IHSS – i.e., “They have been very generous” (LTSS, Encino) and “It has really helped a lot” (LTSS, Beverly Hills).

However, participants frequently noted that it is difficult to find and keep a reliable, suitable IHSS worker - several had experienced problems, including turnover, no-shows for scheduled shifts, and theft. As one said, “I’ve had three different [providers]. The one I considered the best was the most recent one and she just stopped coming” (LTSS, Beverly Hills).

A very few participants had a family member or partner who was their paid IHSS worker, including a spouse and a domestic partner. As one said, “It’s eleven hours a week. And it’s my husband [who is the paid provider] and basically he cooks and cleans.” (LTSS, Beverly Hills). They were positive about this arrangement, and it seemed to work well for them.

LTSS participants without IHSS services knew these were available, usually because they had been mentioned to them by the plan (such as during a needs assessment call), but they had not pursued setup at this point.

Community Based Adult Services

In the English-language groups, almost no participants had ever heard the term Community Based Adult Services (CBAS). It was not familiar to anyone in the Spanish-language groups either. One English-language participant in Encino said she had heard this term from someone at the plan, but she did not know any details about it. A very few participants said they had been made aware of adult daycare opportunities by their care coordinators (but they did not refer to this as CBAS).

Care Transitions

LTSS participants discussed care transitions in greater depth than those in the General segment. Some had been in the hospital or a nursing home since their Cal MediConnect enrollment. Their experiences with care transitions were mixed.

Many were positive about the support they received when they came home from the hospital. Their descriptions of the experience were not detailed, and they seemed to have some difficulty remembering exactly how things went. However, overall, their transitions seemed to have been supported by combined efforts from their plan care coordinators, their doctors, and the hospital. Comments regarding care transitions included the following:

- ✚ “She [my care coordinator] was cleaning everywhere, checking to make sure the medication was the way I should have it, she was really wonderful...two girls from the hospital came to my house before I was discharged and removed carpets so I could be careful and use my walker easily.” (LTSS, Beverly Hills)
- ✚ “I came home, and different nurses would come by and they would give me instructions on things to do...She [my care coordinator] arranged for Meals on Wheels...she arranged for [a lot of] things because I could not do it, and I imagine it had to be from MMP 2.” (LTSS, Beverly Hills)
- ✚ “Oh yes, they sent me everything the next day...in about a week, I got a wheelchair. I got my shower chair, my everything.” (LTSS, Encino)

A very few also mentioned that only their doctors (not the plan or a care coordinator) had arranged for them to get medical care at home after a hospital visit. As one said, “My doctor asked for a nurse to come visit me. I was pretty banged up with falls and what I had” (LTSS, Beverly Hills).

In contrast, a very few described hospital stays after which they received little or no support from the plan or a care coordinator. For example, one participant said, “Nobody helped me. Friends said to me, and you’re going to need this and that. I just called the doctors and I said, ‘I’m going to need this and I’m going to need that’” (LTSS, Encino). According to another participant, she had been discharged from the hospital without appropriate clothing, which she said was “humiliating.” She indicated that she did have a dedicated care coordinator, but she said no one from her plan was aware that she had been hospitalized or provided any transition assistance.

Participants who had IHSS said that their IHSS providers had been ready to help them when they came home from the hospital, which was positive. One, whose girlfriend was his IHSS provider, said she had very capably overseen much of his care transition, in conjunction with his plan care coordinator and his doctors.

IMPACT ON HEALTH, WELL BEING, AND QUALITY OF LIFE

Participants were asked to consider their experience in a Cal MediConnect plan thus far and how it has impacted their health, quality of life, and access to services they needed.

Overall, most participants felt that being enrolled in a Cal MediConnect plan had positively affected their lives.

- Many expressed gratitude for their plans, the health care and services they had access to, and the fact that they got coverage at no cost. Some referred to Cal MediConnect as “a safety net.” Comments to this effect included the following:
 - ✚ “I’m better financially. It’s peace of mind.” (LTSS, Encino)
 - ✚ “I’m so grateful. I would be lost without it.” (General, Beverly Hills).
 - ✚ “It’s a blessing. It is a blessing for me to have all of these services.” (Spanish-Language, San Francisco)
- Participants were usually hesitant to say that their health was better because of Cal MediConnect, because they were aging, had chronic conditions, or had enrolled in the plan after becoming sick. However, many noted that they now took better care of themselves and were encouraged to do so by the plan – such as via check-in calls from care coordinators and persistent reminders from the plan (by mail, over the phone) to get preventive care and vaccines. Some also noted that their diet, blood sugar, and level of activity had improved since enrolling in their plans. In general, they received a lot of “input” from their plans, which at least got them thinking about their health.
- A few English-language participants commented positively about the fact that Cal MediConnect combines Medicare and Medicaid into one program. They felt this was simpler and easier. For example, one said, ‘I think the combination is good. You don’t have to be carrying two cards and figuring out who is paying for what. It’s all in one place. I think it’s easier for the physician to actually tell you when you’re eligible for something new, like Medical Group 4’ (General, San Francisco).
- In Los Angeles, overall, participants were particularly positive about the impact of their Cal MediConnect plans. Several compared their plans positively to their previous coverage in that they were offered more services and it was easier to get the care they needed. This included ease of getting referrals, ease of getting prescriptions filled, access to preferred facilities (i.e., “not just the county hospital”), access to non-medical services (like dental and transportation), and access to conveniently located network pharmacies. As one participant commented, “I totally felt like it was an upgrade. There were more things offered. There was more interaction. They were like, ‘Hey, if you need anything, we are here. What do you need?’... I feel like it was an upgrade” (General, Beverly Hills).

- In San Francisco, English-language participants were grateful for their coverage, but they were less effusive about its positive impact on their lives than those in Los Angeles. Instead, at this point in the discussion, they focused on specialized things that were not available to them through the plans – such as treatments for Lyme disease that were not covered, chiropractic coverage, and coverage for particular drugs.
- Overall, Spanish-language participants were quite positive about their plan’s impact on their lives. Comments to this effect included the following:
 - ✚ “If I didn’t have the plan, I probably wouldn’t be alive...If I was in my own country I would have been dead by now. It has helped.” (Spanish Language, San Francisco)
 - ✚ “It has helped because I’ve been stable. I feel good and I’m stable.” (Spanish Language, San Francisco)
 - ✚ “I have all the services that I can think of.” (Spanish Language, San Francisco)

However, a few Spanish-language participants reiterated that, because of the discussion, they had realized they lacked knowledge about benefits that might be available to them. For example, they said, ‘I don’t know all the information I am supposed to know’ and ‘I’m learning about all of the benefits that are available...you don’t know, and [so] you don’t use many of the things that are available to you.’

At the close of the discussion, participants were asked if there was anything else they would like to see in the demonstration. Responses included increasing coverage for dental and vision, improving reliability of transportation services, adding Fitness Program 1, making medical weight loss programs available, and adding coverage for alternative therapies (including chiropractic and other therapeutic bodywork).

APPENDIX A: DISCUSSION GUIDE AND SCREENERS

CMS FAI - California - Focus Groups

Moderator's Guide

FINAL 7.6.18

I. Introduction (15 minutes)

- A. Purpose: To discuss some of your thoughts regarding your experiences with California's Cal MediConnect program, including with the health care and services you have received since becoming a part of it.

This session will take between an hour and a half and an hour and three quarters. Thanks again for your participation in this important project.

B. Disclosure

- Observation
- Audio recording and video streaming
- Confidentiality assured (your name and comments will not be shared with your plan; a general summary report is created but no identifying personal information is included in it)

C. Ground Rules

- Need to hear from everyone; one at a time.
- No right or wrong answers; your personal opinions.
- Be candid; moderator has no vested interest.

D. Participant Introductions

- Name, occupation, family
- Where you live in the area
- Which health plan do you currently have? (i.e., the name of the company on your card)
- What coverage did you have before your current plan?

II. General Discussion: Cal MediConnect Plans

Everyone here is enrolled in a plan that combines Medicare and Medicaid benefits. You might have heard them called Cal MediConnect plans – and they are provided by a variety of companies.

- A. What do you remember about when you first began participating in your plan? (i.e., started services)?
 - How did you find out about the it? (Probe if not mentioned) How many of you remember receiving information? (Probe: what did you receive?)
- B. Overall, what has your experience in the plan been like so far?
 - What has been good, or worked well for you?
 - What hasn't been as good, or hasn't worked as well for you?
 - Is there anything you would change about the program?
- C. Using a scale of 1 – 5, where 1 is *Not at All Satisfied* and 5 is *Very Satisfied*, how would you rate your satisfaction with your experience in this plan so far? Why?

III. Care Coordination

When you have multiple health needs and providers, it's important to make sure your care from all different sources is organized and that everyone involved is “on the same page” - so that your needs are being met and you are getting the care you need, when you need it. This is called *care coordination*

You might have someone in your life – or even more than one person - who works with you and your providers to make sure this kind of coordination is happening.

- A. Who, if anyone, in your life now does this with and for you (i.e. helps organize and coordinate your care)? Unaided, then probe.
 - Is there anyone from your plan or provider group who helps you? This would be someone you can call from the plan or provider group if you have questions, needs, or problems. If so, who is this person (or persons)? (Moderator will listen to see who they mention - i.e., if they use the term *Care Coordinator* (or Navigator, Case Manager) and as well as if they have a single Care Coordinator (or Navigator, Case Manager) or multiple contacts from the plan or provider group).
 - I'd like to understand how consistent your point of contact with the plan or provider group has been? Have you worked with the same person since joining your plan? Have there been changes or turnover?
 - Does anyone in your family, or perhaps another caregiver (such as a friend or someone else), help organize you care? If so, what is their relation to you?

- If you have an involved family member or other caregiver, how are they involved in your care? Do they communicate with anyone from your plan (such as a Care Coordinator or Navigator, Case Manager) to help you with your needs?
- B. Now I would like to focus more on the help you get from your plan or provider group to make sure your needs are being met. We've covered this a little bit already – but just to confirm:
- How many of you been assigned someone called a Care Coordinator (or Care Navigator, Case Manager) as part of your plan or provider group? (*Show of hands; probe to see if anyone is not sure.*) Maybe you don't use the term *Care Coordinator* (or *Care Navigator, Case Manager*) - so let me read you a description of what I'm talking about.
- A Care Coordinator (or Navigator, Case Manager) could be a trained health professional or a family member or friend who helps manage your care. For example, they help coordinate your care, connect you with PCPs or specialists, educate you about your condition, or arrange other services you might need, such as transportation.*
- If yes, how would you describe what role that person plays in your health care?
- C. For those of you with a Care Coordinator (or Navigator, Case Manager), when you first got a Care Coordinator (or Navigator, Case Manager), what did you think they would be doing for you? Briefly explore.
- (Note: Participants may have more than person who helps to coordinate their care. If so, explore the multiple individuals work together to coordinate care.)*
- D. How has your actual experience with your Care Coordinator (or Navigator, Case Manager) compared to what you expected?
- E. How often does your Care Coordinator (or Navigator, Case Manager) keep in contact with you (whether by in-person visits or telephone contact)?
- Can you call your Care Coordinator (or Navigator, Case Manager) when you need to do so? Do you have a direct phone number for your Care Coordinator?
 - How do you feel about the amount of contact you have? Is it enough, too much, or not enough? Explain.
 - How many of you have had a home visit from a Care Coordinator (or Navigator, Case Manager)?
 - How do you feel about home visits from your Care Coordinator (or Navigator, Case Manager)? What do you like about this approach? What do you dislike?
- F. What has your Care Coordinator (or Navigator, Case Manager) helped you with? How have they helped you with getting your healthcare? Unaided, then explore the following.

- **Appointments.** Has your Care Coordinator (or Navigator, Case Manager) called you after your appointments to ask about them (or discuss next steps, etc.)? If so, how helpful was that?
 - Has your Care Coordinator (or Navigator, Case Manager) accompanied you on any physician visits? Health care or social service appointments? If so, was that helpful? Why or why not?
- **In-home services.** Has your Care Coordinator (or Navigator, Case Manager) helped you arrange for any in-home services? (Examples of this include bathing, grooming, light housekeeping) Which ones? How well did the process of making sure you got that service go?
- **Care transitions.** *[Note – in LTSS groups skip this care transitions section, it is covered in later section of guide]* I'd like to learn more about any experiences you may have working with your Care Coordinator (or Navigator, Case Manager) after being discharged from health care facilities, like a hospital, and then moved back home (or somewhere else to recover). This is called a care transition. As you transitioned from the facility to your home (or somewhere else, like a rehab center), you might have had to consider lots of things - like getting and understanding your discharge instructions, getting needed prescriptions filled, knowing when you have to go back to the doctor for a follow-up visit.

If you went to the Emergency Department or had a hospital or Skilled Nursing Facility admission, when it was time to go home, did the Care Coordinator (or Navigator, Case Manager) or someone else at the health plan or provider group assist you with this process? How did that transition (moving from facility to home) go?

- For example, did you know what to do when you got home from the hospital, Skilled Nursing Facility, or Emergency Department? Did anyone help explain the instructions?
 - What kind of follow-up did you experience after you left? Did your Care Coordinator (or Navigator, Case Manager) or someone else at the health plan or provider group communicate with you about your follow up appointments?
 - Did the Care Coordinator (or Navigator, Case Manager) or someone else from the health plan or provider group meet with you in person at the hospital or SNF? Shortly after you left the hospital?
- **Communication with service providers.** How has the Care Coordinator (or Navigator, Case Manager) helped you communicate with your service providers – that is, any of the people, professionals, or agencies besides your doctor that provide you with the help or support that you need? These service providers may include things like transportation, accessing durable medical equipment, seeing a dentist or getting glasses.

- Does anyone other than your Care Coordinator (or Navigator, Case Manager) help you communicate with service providers? If so, who else does this for you? (This could include family, friend, caregiver, other plan staff such as nurse case manager)
- **Community referrals.** Has the Care Coordinator (or Navigator, Case Manager) referred or linked you to any community resources or assisted you with getting or using any community resources? (This could include social programs or programs that may cover things outside of traditional health care services – meals, transportation, housing, etc.).
- Does anyone other than your Care Coordinator (or Navigator, Case Manager) help you to connect with community resources? If so, who?
- **Education.** Has the Care Coordinator (or Navigator, Case Manager) provided you with educational materials – pamphlets or online resources for example – that to help you to better understand your healthcare needs or achieve your healthcare goals? If so, what kinds of materials have you been provided with? How relevant or useful has this material been?
- G. How many of you have experienced either of the following situations?
- Difficulties or challenges getting services or health care (barriers)
 - Times when you were not getting the services or health care you needed or were “in between” services (gaps)
- If so, tell a little about these experiences. Did your Care Coordinator (or Navigator, Case Manager) work with you on addressing any of these issues? If so, briefly describe that.
- Did anyone else help you address these concerns - such as your family, friends, or another caregiver?
- H. After working with a Care Coordinator (or Navigator, Case Manager) in the plan, how many of you feel that you have a better understanding of [your chronic condition and/or available resources in your area] than before you joined:
- If you do, what has your Care Coordinator (or Navigator, Case Manager) done to make this happen?
 - If not, what do think your Care Coordinator (or Navigator, Case Manager) could do to make you feel better educated about these? What information or knowledge would you need?
- I. Are there any areas that the Care Coordinator (or Navigator, Case Manager) could assist you with that have not been discussed?
- J. In addition to your main Care Coordinator (or Navigator, Case Manager) from your plan or provider group, do you have any other care coordinators from different agencies or service providers that you work with? How would you describe what role that person/those people play in your life and care?

Do your care coordinators (from the plan and other agencies) work together in any way? If so, how? How successful are they at making sure you are getting what you need, both for medical care and other things (like LTSS or mental health services)?

IV. Assessment of Needs, Care Goals, and Creation of Care Plans

Since you enrolled in your Cal MediConnect plan, what, if anything has been done make all of your health needs are being addressed? Moderator will listen for any mention of working with a Care Coordinator (or Navigator, Case Manager) to create a care plan.

(Moderator will allow participants to describe the process of getting their needs met on their own, before asking them specifically about the care planning process.)

- A. Since you've had your Cal MediConnect plan, you might have worked with a Care Coordinator (or Navigator, Case Manager) and others to create something called a care plan. Here is a description of it:

This is a personalized, patient-centered plan for how your particular health needs will be addressed by multiple health care and service providers. To create a care plan, you and your Care Coordinator (or Navigator, Case Manager) identify your needs and how to meet them.

- B. Did you work with your Care Coordinator (or Navigator, Case Manager) to create a care plan? In general, how would you describe this plan and what purpose it serves for you?

Now let's talk about the process you might have gone through to make a plan for your care. Even if you're not sure if you have a care plan, I'm interested in your experiences with some of these things.

- **Assessment.** As a first step in making sure you are getting the care you need, it's necessary to determine what your needs are.

When you started with your plan, how were your needs identified? How was it determined what services you needed, for medical care and anything else?

For example, did you meet with your Care Coordinator (or Navigator, Case Manager) and any others to talk about your needs?

- If not your Care Coordinator (or Navigator, Case Manager), did someone else help you to complete an assessment regarding your health and goals?
- **Goals.** After your needs were determined, do you recall setting goals related to your health and care with your Care Coordinator (or Navigator, Case Manager)?

(Examples of goals could include lowering blood sugar, losing weight, improving mobility so you could go to church or visit family members). If so:

(Moderator will listen for specific goal types – i.e., abstract vs. concrete goals)

- What was the goal-setting process like?
 - How well did you feel your Care Coordinator (or Navigator, Case Manager) listened to you about your goals?
 - How well did your Care Coordinator (or Navigator, Case Manager) understand you and then express your goals accurately? In other words, how well did the set of goals that was created match with what you had in mind?
 - Did you develop a strategy for achieving your goals – including next steps?
 - How, if at all, is progress toward meeting your goals measured along the way? How do you know/find out if you have made progress?
- Did you receive a copy of your care plan? How helpful/important is it to have a copy?
- Have you ever talked to your Care Coordinator (or Navigator, Case Manager) about changing or updating your care plan? If so, what was that like?
- C. What difference do you think having a care plan has made on how you get your care? Moderator will probe for any positive or negative outcomes of creating a care plan.
- D. How has having a care plan helped you to reach your health care goals?

V. **Questions for LTSS Groups Only**

Let's talk a little more about your experiences getting some additional services to support you and your health.

A. **First, we'll talk about IHSS (In Home Support Services).**

- You might have already mentioned some of these, but remind me - what kinds of IHSS services have you had experience with so far?
- How long have you been receiving these IHSS services? Who is your IHSS provider or who provides you with these services?
- About how much time per week (i.e., hours), or how often, do you receive these services? Daily, a few times a week, etc.?
- Has your need for and use of IHSS services increased or decreased over time (i.e., the last few years)?
- How has your Care Coordinator (or Navigator, Case Manager) been involved with these IHSS services?

- If you felt like you needed more hours of support, or more services, have you talked to your Care Coordinator (or Navigator, Case Manager) about that? Were they able to help you?
 - Compared to the past, have there been any changes this year to how you're your Care Coordinator (or Navigator, Case Manager) helps you get IHSS services? Have you noticed anything different or experienced any changes? If so, please describe.
- For those of you who have not received IHSS services, have you ever tried to get these services? What was that experience like? How has your plan or provider group, or care coordinator/navigator helped you in this regard?
 - If you were referred to the county, how did that process work? How easy or difficult was it to get connected with the services you needed through the county?

B. Community Based Adult Services (CBAS) Has anyone has used adult day care programs and services (through something called Community Based Adult Services CBAS? (Show of hands)

[Note to moderator: CBAS includes - professional nursing services; physical, occupational and speech therapies; mental health services; therapeutic activities; social services; personal care; a meal; nutritional counseling; transportation to and from the participant's residence and the CBAS center.]

- How did you find out about CBAS and the center where you go? How did you get connected to those services and the center? Who helped to get you involved there?
- Did your plan have a role in connecting your it? What about your Care Coordinator (or Navigator, Case Manager) from your plan or provider group? I'd like to know how involved and helpful your plan was in making it possible for you to go to the center.
- Overall, how well did the process work of getting you set up with the center and services you get there?

C. Care transition from nursing facilities or hospitals. I'm interested in hearing about your experiences after being discharged and going home after short-term stays in nursing facilities or hospitals.

- Has anyone had this experience in the recent past? Were you in a hospital or a nursing facility?
- What was the experience like of going home after being discharged? How well was this process planned? How organized did it seem to be?
- Did anyone assure that you got all that you needed? Medication? PT? Food? Etc.?
- Once at home, was your IHSS worker ready to work with you? How quickly was it available? (e.g., was it available right away?)

- Did you know what to do when you got home? Did anyone help explain the instructions?
- What kind of follow-up support did you experience after you left the facility? Did your Care Coordinator (or Navigator, Case Manager) communicate with you about your follow up appointments?
- How well did the plan or provider group help make sure you could get to your follow up appointments with your doctors?
- If you have a care plan, was that updated to make sure your needs were being met after coming home from a hospital/facility stay?

VI. Additional Benefits Discussion

I'd like to understand a little more about some additional benefits you might have accessed since you've been in your plan.

A. Transportation

- What kinds of transportation benefits are available to you to help get you to your non-emergency medical care? Are you aware of any?
- If so, have you used any transportation services? Which ones have you used? Unaided, then mention the following: Lyft, wheelchair accessible transportation, or public transportation (providing bus tokens).
- If you have (or have had in the past) any difficulties with mobility, were you able to get the type of transportation you needed? (Listen for any mention of receiving the wrong type of transportation -- i.e., that did not address mobility/ambulation needs).
- How do you get information about the transportation benefits? Who has provided you with information? What kinds of information have you been provided with?
- Are there any limits on how many rides you can get? Has that changed since you've had your plan? (*Note: used to be 30 rides, now is unlimited – probe for awareness of this change*)
- If you have used a transportation service, what has that experience been like?
- If you have used a service that has picked you up (like Lyft or a medical transport company like LogistiCare), how well have they performed in terms of the following:
 - Timeliness/arriving on schedule
 - Reliability
 - Being courteous, professional, and respectful
- If you have had any problems with transportation, what were they? How did they get handled and resolved?

B. Care Plan Options

Sometimes people need help and services that go a little beyond the regular things their health plan offers. These are services to help enhance care and help people stay in their homes. For example, this might include home improvements, meals delivered to the home, personal care services (help with bathing or clothing), home modifications, help with purchasing groceries, and personal emergency response systems.

These services are offered in addition to any IHSS you might receive. These services might be called CPO or Care Plan Option Services, but your plan might call them something else. They go a little beyond the regular services you might typically receive from the plan.

- Have you ever heard of plans offering these extra services?
- Have there ever been times when you needed these types of extra services to help you stay in your home?
 - For example, you might need an air conditioning unit, so you could safely stay in your home in the summertime when it might get dangerously hot? Or a ramp or modification that helped you more easily enter and exit your home?
- If so, what kinds of extra service did you get? How easy or difficult was it for you to get what you needed? Were the services covered by your plan?
- How did you get information about these services? Did you get information from your plan? From Medi-Cal? Someone else?

VII. Impact of Cal MediConnect on Health, Well-Being and Quality of Life

Take a moment to consider your experience with your plan up until now.

- A. Has being a part of your plan had any impact on your health? If so, what? Probe for any related health improvement.
- B. How has being in your plan affected your quality of life?
- C. Have you been able to get the services you need (health or otherwise) more easily now than you could before? If so, how has that affected you? If not, what do you still need?

VIII. Conclusion (5 minutes)

- A. What have I not asked you about the Cal MediConnect program that I should have asked? Is there anything else you would like to see in the program? If so, please share.
- B. Check with clients for any additional questions.

Alan Newman Research

CMS – FAI (Financial Alignment Initiative) Focus Groups - Pr # 254-104

California – Tuesday, July 10 through Thursday, July 12, 2018

English-Language Screener

- CALL FROM LIST PROVIDED / ASK TO SPEAK TO PERSON NAMED ON LIST
- PARTICIPANT MUST BE THE DECISION-MAKER (OR JOINT DECISION-MAKER) REGARDING THEIR HEALTHCARE OPTIONS (LIKE WHAT KIND OF INSURANCE THEY CARRY AND WHAT PROVIDERS THEY ELECT TO SEE)
- IF PERSON ON THE LIST IS NOT A DECISION-MAKER, TERMINATE >

NOTE: Should be listed to qualify. However, if person listed is unable to answer your questions or participate in the research study due to their disability, get referral to their caregiver or proxy. Get specifics and hold.

- RECRUIT 10 PER GROUP

[RECRUITER: RECORD PLAN NAME FROM LIST]

[RECORD LTSS “YES/NO” FROM LIST] _____

[IF “YES” TO “LTSS” >> ATTEMPT FOR LTSS GROUPS >> MARKET TBD]

[IF “NO” TO “LTSS” >> ATTEMPT FOR GENERAL BENEFICIARIES GROUPS >> MARKET TBD]

Hello, I’m _____ with _____, an independent research firm. We are not selling or promoting any product or service. We are working on a project for the State of California and the Centers for Medicare and Medicaid Services (CMS) as part of an effort to improve member care and services. We would like to learn more about the health plan you are currently enrolled in. We are interested in hearing your perspective regarding the program. Specifically, we are interested in learning what works and what doesn’t work for you and how the health plan can better meet your needs.

If you are interested in helping with the project and you meet its requirements, we will invite you to take part in an informal discussion group with a few other members. The focus group discussion will last no more than 2 hours. As compensation for your time, you will receive a \$65 incentive as well as a travel reimbursement of \$60.

May I ask you a few questions to see if you qualify to participate? My questions will only take a couple of minutes. *All of your answers will remain confidential and the information will only be used for this study.*

1. Who in your household is most responsible for decisions regarding your (or the person listed's) healthcare choices such as what kind of health insurance [you/they] carry and what providers (doctors, hospitals, etc.) [you/they] use for healthcare services? Is that?

You/self _____

Joint decision/shared equally with spouse or someone else _____

GET SPECIFICS AND HOLD >> Someone else mostly makes these decisions for me _____

2. The Centers for Medicare & Medicaid Services' records show that you are (or the person you are giving care to is) currently receiving **both** Medicare and Medicaid benefits to offset the cost of medical expenses. Is that correct?

CONTINUE >> Yes, receives **both** Medicare and Medicaid _____

TERMINATE >> No, receives Medicare only _____

TERMINATE >> No, receives Medicaid only _____

TERMINATE >> No, receives neither Medicaid nor Medicare _____

(Specify – record explanation) _____ DK, Unsure, Other _____

[MUST BE RECEIVING BOTH MEDICARE AND MEDICAID BENEFITS TO QUALIFY]

[IF UNSURE, GET SPECIFICS & HOLD FOR APPROVAL]

3. What is the name of your current Cal MediConnect plan?

ASK RESPONDENT TO READ THE INFORMATION ON THEIR MEDICARE/MEDICAID CARD FOR Q.3

[RECORD VERBATIM AND CLASSIFY ON CHART BELOW]

[ATTEMPT GOOD MIX OF PLANS REPRESENTED]

- 3A. How long have [you/they] been enrolled in [INSERT PLAN NAME]?

3B. In the last 12 months, have [you/they] been **continuously** enrolled in [INSERT PLAN NAME], or have [you/they] previously dropped the plan, or been disenrolled and later re-enrolled?

MUST SAY “YES” >> Continuous enrolled for 12 months _____

ASK HOW LONG AND HOLD “YES”>>Continuous, less 12 months _____

GET SPECIFICS AND HOLD >>Dropped _____

[NOTE: IF RESPONDENT HAS SWITCHED PLANS WITHIN Cal MediConnect PROGRAM, CAN CONTINUE >> IF NOT, HOLD & CHECK WITH ANR FOR POSSIBLE CONSIDERATION] [IF LESS THAN 12 MONTHS CONTINUOUSLY ENROLLED, ASK HOW LONG AND HOLD]

4. Do you have a care coordinator? A Care Coordinator can be a trained health professional, family member or friend who helps manage your care. For example, they help connect you with primary care physicians or specialists, educate you about your condition, or arrange other services you might need.

Yes, a trained professional through Cal MediConnect _____

Yes, a trained professional through your doctor’s office _____

HOLD>>Yes, a friend or family member _____

GET SPECIFICS AND HOLD>>Yes, other _____

THANK & TERMINATE >>No _____

SCREEN & HOLD >> Don’t Know/Unsure _____

4A. Do you (or the person you are a proxy for) have a **Care Plan** through your Cal MediConnect plan? A Care Plan is a personalized plan for how your particular health and support needs will be addressed by multiple health care or service providers.

Yes _____

No _____

Don’t Know/Unsure _____

5. **[ASK LTSS]**

Are you (or the person you are giving care to) receiving any of the following MediCal benefits (or participating in any of the following MediCal programs) as part of [your/his or her] healthcare services?

IHSS program (*In-Home Supportive Services program*) _____ (Yes/No/DK)

In-Home Supportive Services (IHSS) is considered an alternative to out-of-home care. It is a self-directed personal care service program that allows beneficiaries to hire, direct, and fire support workers to provide personal assistance services in their homes.

The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, grooming, bathing, etc.), accompaniment to medical appointments, and protective supervision for the mentally impaired. Often, an IHSS worker is also a family member or friends hired to do the work.

Community Based Adult Services (CBAS) _____ (Yes/No/DK)

CBAS is a community-based day health program for older adults and adults with certain chronic medical, cognitive or mental health conditions or disabilities who are at risk of needing institutional care. This program used to be called Adult Day Health Care (ADHC).

Multipurpose Senior Services Program (MSSP) _____ (Yes/No/DK)

Multi-Purpose Senior Services Program (MSSP) helps you work with your doctors, specialists, and other providers. It also helps you get needed equipment and services.

MSSP provides social and health care management for frail elders who are eligible for placement in a nursing facility but want to remain in the community.

- **QUOTA: NEED TO RECRUIT “SOME” LTSS, WHO RECEIVE ONE OR MORE OF THE ABOVE SERVICES. 6. In the past 12 months**, how often have [you/has the person you are a proxy for] seen a health care provider like a doctor or a nurse practitioner?

THANK & TERMINATE >> 1 time _____

2-5 times _____

6-10 times _____

More than 10 times _____

THANK & TERMINATE >> Have not visited a healthcare provider in the past year _____

7. Have you (or has the person you are serving as a proxy for) ever been diagnosed by a physician or another provider with any of the following chronic conditions?
 - A. Spinal cord injury _____
 - B. Traumatic Brain Injury _____
 - C. Stroke _____

- D. A neurological condition like Parkinson’s disease or Multiple Sclerosis _____
- E. Diabetes _____
- F. Congestive Heart Failure _____
- G. Cardiovascular disease (including heart disease, hypertension, or high blood pressure) _____
- H. Chronic Obstructive Pulmonary Disease (COPD) or chronic bronchitis _____
- I. Cancer (of any type) _____
- J. Osteoarthritis, osteoporosis, hip fracture _____
- K. Other _____

[FOR GENERAL POPULATION (Encino & SF) >> NEED NOT MENTION A DIAGNOSIS TO CONTINUE]

[FOR LTSS (Beverly Hills) - SHOULD MENTION 1 OR MORE DIAGNOSIS TO CONTINUE]

- 8. Do you need help with everyday activities like bathing & dressing, meal preparation or getting out of bed or a chair?

MUST SAY “YES” FOR LTSS >> Yes _____

CONTINUE AS GENERAL POPULATION ONLY >> No _____

- 9. Have you ever used transportation services provided through the Cal MediConnect program and/or through [INSERT PLAN NAME]? For example, you may have needed transportation to get to a medical appointment. These transportation services may have been provided by Uber, Lyft, or LogistiCare. It is also possible you may have been provided bus tokens or taxi vouchers.

ATTEMPT TO RECRUIT “SOME” >> Yes _____

No _____

SCREEN & HOLD >> Don’t Know/Unsure _____

- 10. Please tell me your age.

_____ **[RECORD ACTUAL AGE & CATEGORIZE BELOW]**

[NEED GOOD MIX OF APPROPRIATE AGES REPRESENTED]

THANK & TERMINATE >> Under 21 _____

22-34 _____

35-44 _____

35-44 _____

45-54 _____

55-64 _____

65-74 _____

*75-79 _____

***RECRUIT MAX 1 PER GROUP > 80 or older** _____

**For participants 75 years old or older years of age, pay careful attention to the “articulation question” response before inviting.*

11. What is the highest level of education you have completed?

[NEED GOOD MIX]

[MUST HAVE REPRESENTATION FROM ALL QUALIFYING CATEGORIES]

Some high school/Less than high school graduate _____

High school graduate (or GED) _____

Some college (or 2-year/Associates Degree) _____

MAX. 2 PER GROUP >> College graduate _____

TERMINATE >> Post graduate studies or degree _____

12. So that we can be sure that all backgrounds are represented in our study, please tell me your race or ethnic origin. Are you?

[NEED MIX – ATTEMPT 1/3 MINORITY REPRESENTATION]

Caucasian/white _____

African-American/black _____

Hispanic/Latino _____

ASK QUESTION 12A >> Asian _____

American Indian _____

Middle Eastern _____

(Specify) _____ Other _____

12A. **[IF ASIAN SELECTED IN Q12A]**What is your family’s country of origin?

[RECORD VERBATIM ANSWER]

13. **[Record Gender]** **[NEED GOOD MIX – ATTEMPT 50/50]**

[BUT IF NECESSARY MAY RECRUIT 2/3 FEMALE, 1/3 MALE]

Male _____

Female _____

14. This question is one that you can have some fun with. There are no “right” or “wrong” answers.

Please take a minute to think about it and tell me, “If you could have dinner with any person in history (living or dead), who would it be and why?”

[RECORD VERBATIM ANSWER >> ONLY RECRUIT THOSE PEOPLE WHO ARE ARTICULATE AND FORTHCOMING WITH THEIR RESPONSES]

15. As I mentioned earlier, we are attempting to put together an informal discussion group among people who participate in the Cal MediConnect program. The group will be conducted in English and we may be reviewing some written materials (written in English.) Will you be comfortable sharing your views and evaluating some written materials in a group situation?

Yes _____

THANK & TERMINATE >> No _____

- 15A. Do you have any physical or emotional conditions that would prevent you from participating in a round-table group discussion? (*That is, do you need any kind of assistance in order to be able to attend?*)

GET SPECIFICS AND HOLD >> Yes _____

No _____

[Note: Interviewer will need to get specific needs & contact information.]

- **What kind of assistance will you need to be able to participate in this discussion?**

[RECORD AND CHECK WITH ANR BEFORE SCHEDULING]

- 15B. Which of the following statements best describes you in a group situation?

[READ STATEMENTS]

- A. I have no difficulty expressing my opinions in front of others. I enjoy a group discussion where different opinions are being expressed [CONTINUE] >> _____
- B. I tend to be very quiet and do not usually express my opinions in a group situation [TERMINATE & TALLY] >> _____
- C. I like a group discussion, and with some encouragement, I will share my opinions with others. [CONTINUE] >> _____ [INVITE TO APPROPRIATE GROUP]

Thank you for taking the time to answer our questions. As I mentioned earlier, we are conducting a research study on behalf of Cal MediConnect and CMS with members of the [INSERT PLAN NAME] and would like to invite you to take part. The purpose of the study is to hear your views about your health care plan program and to improve services and support. In order to accomplish this, we would like to invite you to take part in an in formal group discussion with other members. The discussion will last no longer than **2 hours** and will be both enjoyable and beneficial. To serve as a thank you and to compensate you for your time, you will receive an honorarium of **[\$65.] You will also receive an additional \$60 to offset any transportation expenses incurred in getting to and from the discussion.**

[Incentive amounts: Scheduled group discussion: \$65 incentive + \$60 transportation expense.]

The group discussion in [give city/location] is being scheduled on [DATE] at [GIVE AVAILABLE TIMES.]

No one will attempt to sell you anything and no one will call on you as a result of your participation.

I am confident that you will enjoy the exchange of information. This is an important research effort and we hope that you will be part of it. Due to limited space, we can only invite a few people to attend. Can we schedule your participation?

[If yes, read]

If you need glasses for reading, please be sure to bring them with you when you come to the discussion.

Also, please bring a picture ID. You may be asked to show it to be admitted into the discussion.

Lastly, please bring your Medicaid or your health plan Member ID card with you to the group.

[RECORD MARKET/ GROUP]

Los Angeles (Encino), CA **Tuesday, July 10, 2018**
11:00 a.m. **General Beneficiaries** _____
1:30 p.m. **General Beneficiaries** _____

Los Angeles (Beverly Hills), CA **Wednesday, July 11, 2018**
11:00 a.m. **LTSS** _____
1:30 p.m. **LTSS** _____

San Francisco, CA **Thursday, July 12, 2018**
(NOTE: See Spanish-Language Screener for earlier groups)
1:30 p.m. **General Beneficiaries** _____
4:00 p.m. **General Beneficiaries** _____

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____

ZIP CODE: _____

PHONE: (DAY) _____

(EVE) _____

(CELL) _____

(EMAIL) _____

Alan Newman Research

CMS – FAI (Financial Alignment Initiative) Focus Groups - Pr # 254-104

California – Tuesday, July 10 through Thursday, July 12, 2018

FILTRO EN ESPAÑOL

- DEBE REALIZARSE EN ESPAÑOL
- LLAMAR PERSONAS DE LAS LISTA PROPORCIONADA/PIDA HABLAR CON LA PERSONA QUE APARECE EN LA LISTA
- EL/LA PARTICIPANTE DEBE SER LA PERSONA PRINCIPAL EN LA TOMA DE DECISIONES (O COMPARTIR LA TOMA DE DECISIONES CON ALGUIEN MAS) CON RESPECTO A SUS OPCIONES EN LA ATENCION DE LA SALUD (POR EJEMPLO, QUE CLASE DE SEGURO TIENEN Y QUE PROVEEDORES ESCOGIERON)
- SÍ LA PERSONA QUE APARECE EN LA LISTA NO ES LA PERSONA PRINCIPAL EN LA TOMA DE DECISIONES, TERMINE >

NOTA: Debe estar en la lista para poder participar. Sin embargo, si la persona no puede responder a sus preguntas debido a su incapacidad, pida hablar con su cuidador(a) o la persona que esté a cargo de su cuidado. Obtenga los detalles y manténgalo(a).

- RECLUTE 10 POR GRUPO >>

[RECLUTADOR: ESCRIBA EL NOMBRE DEL PLAN QUE APARECE EN LA LISTA]

[ESCRIBA LTSS “SI/NO” DE LA LISTA] _____

[SÍ RESPONDE “NO” A “LTSS” >> INTENTE PARA LOS GRUPOS EN ESPAÑOL >> MERCADO POR DEFINIR]

Hola, mi nombre es _____ y estoy con _____, una firma de investigación independiente. No estamos vendiendo ni promoviendo ningún producto o servicio. Estamos trabajando en un proyecto para el Estado de California y los Centros de Servicios de Medicare y Medicaid (CMS) como parte de un esfuerzo para mejorar la atención y los servicios para los miembros. Nos gustaría saber un poco más sobre el plan de salud en el que está inscrito(a) actualmente. Estamos interesados en conocer su punto de vista con respecto al programa. Específicamente, estamos interesados en saber para usted qué funciona, qué no funciona y cómo el plan de salud puede satisfacer mejor sus necesidades.

Si está interesado(a) en ayudarnos con el proyecto y usted reúne los requisitos, lo invitaremos a participar en una charla en grupo informal con algunos otros miembros. La charla en grupo durará máximo 2 horas. Como compensación por su tiempo, usted recibirá un incentivo de \$65 y un reembolso de \$ 60 para el transporte.

¿Puedo hacerle algunas preguntas para ver si reúne los requisitos para participar? Mis preguntas solo tomarán un par de minutos. **Todas sus respuestas serán confidenciales y la información solo será utilizada para este estudio.**

1. ¿En su hogar quién es la persona más responsable por las decisiones relacionadas con sus opciones (o de la persona que aparece en la lista) en el cuidado de la salud, tales como: ¿qué tipo de Seguro de salud tiene [usted/ellos] y que proveedores (doctores, hospitales, etc.) [usted/ellos] usan para los servicios del cuidado de la salud? ¿Es.....?

Usted _____

Una decisión conjunta/compartida por igual con su cónyuge o alguien más _____

OBTENGA LOS DETALLES Y MANTENGA >> Alguien más toma esas decisiones por mí _____

2. Los registros de los centros de servicios del Medicare y Medicaid muestran que usted (o la persona a la cual usted cuida) está actualmente recibiendo beneficios de **ambos**, Medicare y Medicaid para compensar los costos de los gastos médicos. ¿Es eso correcto?

CONTINUE >> Si, recibe **ambos** Medicare y Medicaid _____

TERMINE >> No, recibe solamente Medicare _____

TERMINE >> No, recibe solamente Medicaid _____

TERMINE >> No, no recibe ni Medicaid o Medicare _____

(Especifique – escriba la explicación) _____

No sabe, No está Seguro(a), Otro _____

[DEBE ESTAR RECIBIENDO BENEFICIOS DE AMBOS MEDICARE Y MEDICAID PARA CALIFICAR]

[SI NO ESTA SEGURO(A), OBTENGA LOS DETALLES Y MANTENGA PARA APROBACION]

3. ¿Cuál es el nombre de su plan Cal MediConnect actual?

PIDA AL PARTICIPANTE QUE LEA LA INFORMACION EN SU TARJETA MEDICARE/MEDICAID PARA LA P.3]

[ESCRIBA LA RESPUESTA LITERALMENTE Y CLASIFICAR MAS ABAJO] [INTENTE UNA BUENA MEZCLA DE PLANES REPRESENTADOS]

3A. ¿Por cuanto tiempo [usted/ellos] ha estado inscrito en [INSERTE NOMBRE DEL PLAN]?

3B. ¿En los últimos 12 meses [usted/ellos] ha estado inscrito **continuamente** en [INSERTE NOMBRE DEL PLAN], o [usted/ellos] anteriormente ha abandonado el plan o ha cancelado su inscripción al plan y luego se re-inscribió?

DEBE DECIR “SI” >> Ha estado inscrito continuamente por 12 meses _____

PREGUNTE POR CUANTO TIEMPO Y MANTENGA “SI” >> Ha estado inscrito continuamente menos de 12 meses _____

OBTENGA LOS DETALLES Y MANTENGA >> Abandonó _____

[NOTA: SÍ EL PARTICIPANTE HA CAMBIADO PLANES DENTRO DEL PROGRAMA Cal MediConnect, PUEDE CONTINUAR >> SÍ NO, MANTENGA Y VERIFIQUE CON ANR PARA UNA POSIBLE CONSIDERACION] [SÍ HA ESTADO INSCRITO CONTINUAMENTE POR MENOS DE 12 MESES, PREGUNTE POR CUANTO TIEMPO Y MANTENGA]

4. ¿Tiene usted un coordinador de atención? Un coordinador de atención es un profesional de la salud entrenado, un miembro de la familia o un amigo(a) que le ayuda a manejar su cuidado. Por ejemplo, lo ayudan a conectarse con médicos primarios o especialistas, le enseñan sobre su condición o coordinan otros servicios que usted pudiera necesitar.

Si, un profesional entrenado a través de Cal MediConnect _____

Si, un profesional entrenado a través de la oficina de su doctor _____

MANTENGA >> Si, un amigo(a) o miembro de la familia _____

OBTENGA LOS DETALLES Y MANTENGA >> Si, otro _____

AGRADEZCA Y TERMINE >> No _____

CONTINUE CON EL FILTRO Y MANTENGA >> No sabe/no está Seguro(a) _____

4A. ¿Tiene usted (o la persona por la cual usted es responsable) un **Plan de salud/Care Plan** a través de su plan Cal MediConnect? Un plan de salud/Care Plan es un plan personalizado sobre como sus necesidades específicas de salud y apoyo serán atendidas por múltiples proveedores del cuidado de la salud o proveedores de servicios.

Si _____

No _____

No sabe/no está Seguro(a) _____

5. ¿En los últimos 12 meses, con qué frecuencia [usted/ o la persona por la cual usted es responsable] ha visto un proveedor de atención médica, por ejemplo, un doctor o una enfermera practicante?

AGRADEZCA Y TERMINE >> 1 vez _____

2-5 veces _____

6-10 veces _____

Más de 10 veces _____

AGRADEZCA Y TERMINE >> No ha visitado un proveedor de cuidados de la salud en el último año _____

6. ¿Alguna vez usted (o la persona por la cual usted es responsable) ha sido diagnosticado por un doctor u otro proveedor de atención médica con alguna de las siguientes condiciones crónicas?

- A. Lesión de la médula espinal _____
- B. Lesión cerebral traumática _____
- C. Infarto _____
- D. Una condición neurológica como la enfermedad de Parkinson o esclerosis múltiple. _____
- E. Diabetes _____
- F. Insuficiencia cardíaca congestiva _____
- G. Enfermedad cardiovascular (incluyendo enfermedades cardíacas, hipertensión o presión sanguínea alta. _____
- H. Enfermedad pulmonar obstructiva crónica (COPD) o bronquitis crónica _____
- I. Cáncer (de cualquier tipo) _____
- J. Osteoartritis, osteoporosis, fractura de la cadera _____
- K. Otra _____

[NO DEBE MENCIONAR UN DIAGNOSTICO PARA CONTINUAR]

7. ¿Necesita usted ayuda con las actividades diarias tales como bañarse y vestirse, preparación de alimentos o levantándose de la cama o de una silla?

Si _____

No _____

8. ¿Alguna vez ha usado servicios de transporte provistos a través del programa Cal MediConnect y/o a través de [INSERTAR NOMBRE DEL PLAN]? Por ejemplo, es posible que haya necesitado transporte para ir a una cita médica. Estos servicios de transporte pueden haber sido provistos por Uber, Lyft o LogistiCare. También es posible que le hayan entregado tokens de autobús o cupones de taxi.

INTENTE RECLUTAR "ALGUNO" >> SI _____

No _____

CONTINUE CON EL FILTRO Y MANTENGA >> No sabe/no está Seguro(a) _____

9. Por favor dígame su edad.

_____ [ESCRIBA LA EDAD ACTUAL Y COLOQUELA EN EL RANGO DE EDADES QUE LE CORRESPONDE A CONTINUACION] [SE NECESITA UNA BUENA MEZCLA DE EDADES APROPIADAS REPRESENTADAS]

AGRADEZCA Y TERMINE >> Menor de 21 _____

22-34 _____

35-44 _____

45-54 _____

55-64 _____

65-74 _____

*75-79 _____

*RECLUTE MAX 1 POR GRUPO > 80 años o mayor _____

** Para participantes de 75 años de edad o mayores, preste especial atención a la respuesta en la "pregunta de articulación" antes de invitar.*

10. ¿Cuál es el nivel más alto de educación que ha completado?

[NECESITA UNA BUENA MEZCLA]

[DEBE TENER REPRESENTACIÓN DE TODAS LAS CATEGORÍAS QUE CALIFIQUEN]

Algo de secundaria/menos que graduado de secundaria _____

Graduado de secundaria (o GED) _____

Algo de universidad (o 2-años/un diploma de asociado) _____

MAX. 2 POR GRUPO >> Graduado de la universidad _____

TERMINE >> Grados o estudios postgrados _____

11. Para que podamos estar seguros de que todos los antecedentes están representados en nuestro estudio, por favor dígame su raza o antecedente étnico. ¿Usted es?

Caucásico(a)/blanco(a) _____

Afroamericano(a)/negro(a) _____

RECLUTE 100% >> Hispano(a)/Latino(a) _____

HAGA LA PREGUNTA 11A >> Asiático(a) _____

Indio Americano _____

Medio Oriente _____

(Especifique) _____ Otro _____

11A. [SÍ ASIÁTICO HA SIDO SELECCIONADO EN Q11A]

¿Cual es el país de origen de su familia?

[ESCRIBA EXACTAMENTE LA RESPUESTA]

12. ¿Cuál es su país de origen? _____

[Por ejemplo, *Mexicano(a)/Mexicanoamericano(a), Puertorriqueño(a), Cubano(a), Centroamericano(a) (Salvadoreño(a), Nicaragüense, Panameño(a), etc.), Suramericano(a): (Venezolano(a), Peruano(a), etc.)*]

[ESCRIBA E INTENTE OBTENER UNA BUENA MEZCLA]

13. ¿Cuál es idioma principal que usted habla en su hogar?

[DEBE HABLAR ESPAÑOL COMO EL IDIOMA PRINCIPAL PARA PODER CONTINUAR]

- 13A. Diría que en su hogar usted habla: [LEA LA LISTA]

Español todo el tiempo _____

Español más de la mitad del tiempo _____

CONTINUE CON EL FILTRO Y MANTENGA >> Español e inglés por igual _____

TERMINE >> Español menos de la mitad del tiempo _____

TERMINE >> Algo más _____

[ESPANOL DEBE SER EL IDIOMA QUE PRINCIPALMENTE SE HABLA EN EL HOGAR (Q.13) Y SE DEBE HABLAR MAS DE LA MITAD DEL TIEMPO (Q.13A) PARA CALIFICAR]

14. [Escriba el género] [SE NECESITA UNA BUENA MEZCLA– INTENTE 50/50]

[PERO SI ES NECESARIO PUEDE RECLUTAR 2/3 MUJERES, 1/3 HOMBRES]

Hombre _____

Mujer _____

15. Esta es una pregunta con la que se puede divertir un poco. No hay respuestas “correctas” o “incorrectas”.

Por favor tómese un minuto para pensarlo y dígame: "Sí pudiera cenar con cualquier persona en la historia (viva o muerta), ¿Quién sería y por qué?"

[ESCRIBA EXACTAMENTE LA RESPUESTA]>> SOLAMENTE RECLUTE AQUELLAS PERSONAS QUE SON ARTICULADAS Y RESPONDEN DE BUENA MANERA.]

16. Como le mencioné anteriormente, estamos tratando de armar una charla en grupo informal en español entre personas que participan en el programa Cal Medicconnect. El grupo se llevará a cabo en español. ¿Se sentirá cómodo compartiendo sus puntos de vista y evaluando algunos materiales escritos mientras esta en un grupo?

Si _____

AGRADEZCA Y TERMINE >> No _____

16A. ¿Tiene alguna condición física o emocional que le impida participar en una charla en grupo? (*Es decir, ¿necesita algún tipo de ayuda para poder asistir?*)

OBTENGA LOS DETALLES Y MANTENGA >> Si _____

No _____

[Nota: El entrevistador deberá obtener las necesidades específicas del participante y su información de contacto.]

- **¿Qué clase de ayuda usted necesitaría para poder participar en este grupo?**

[ESCRIBA Y REVISE CON ANR ANTES DE PROGRAMAR]

16B. ¿Cuál de las siguientes frases a usted lo describe mejor cuando está en un grupo?

[LEA LAS FRASES]

No tengo ninguna dificultad en expresar mis opiniones en frente de otras personas. Disfruto de una charla en grupo donde se expresan diferentes opiniones

[CONTINUE] >> _____

D. Tengo tendencia a ser callado(a) y usualmente no expreso mis opiniones en una charla en grupo **[TERMINE Y HAGA UN CONTEO] >> _____**

E. Me gustan las charlas en grupo y con un poco de motivación compartiré mis opiniones con otras personas. **[CONTINUE] >> _____**

[INVITE AL GRUPO QUE LE CORRESPONDE]

Gracias por tomar tiempo para responder nuestras preguntas. Como mencioné anteriormente, estamos llevando a cabo un estudio de investigación en nombre de Cal MediConnect y CMS con miembros de **[INSERTAR NOMBRE DEL PLAN]** y nos gustaría invitarlo(a) a que participe en el estudio. El propósito del estudio es escuchar sus puntos de vista sobre su programa de plan de atención de la salud y mejorar los servicios y la asistencia. Para lograr esto, nos gustaría invitarlo(a) a participar en una charla en grupo con otros miembros. La charla tendrá una duración máxima de **2 horas** y será una charla agradable y beneficiosa. Como agradecimiento y para compensarle por su tiempo, usted recibirá un pago de **[\$65]**. **También recibirá \$60 adicionales para compensar los gastos de transporte para ir y regresar de la charla.**

[Incentivos: Charla en grupo programada: incentivo \$65 + gastos de transporte \$60.]

La charla en grupo en **[ciudad/localización]** está siendo programada para **[FECHA]** a las **[PROPORCIONE LOS HORARIOS DISPONIBLES]**

Nadie intentará venderle nada y nadie lo llamará como resultado de su participación.

Estoy seguro de que disfrutará el intercambio de información. Este es un esfuerzo importante de investigación y esperamos que usted sea parte de él. Debido al espacio limitado, solo podemos invitar a algunas personas a asistir. ¿Podemos programar su participación?

[Si responde si, lea ...]

Si usted necesita lentes para leer, por favor asegúrese de traerlos cuando venga a la charla.

También, por favor traiga una identificación con foto. Se le puede pedir para poder participar en la charla.

Por último, por favor traiga a la charla su tarjeta de Medicaid o su tarjeta de identificación de miembro de su plan de salud.

[ESCRIBA EL MERCADO/ GRUPO]

San Francisco, CA Jueves, Julio 12, 2018

10:00 a.m. General Beneficiaries – Spanish speaking _____

12:30 p.m. General Beneficiaries – Spanish speaking _____

NOMBRE: _____

DIRECCION: _____

CIUDAD: _____

ESTADO: _____

CODIGO POSTAL: _____

TELEFONO: (DIA) _____

(NOCHE) _____

(CELULAR) _____

(CORREO ELECTRONICO) _____