

September 2017

Cal MediConnect Enrollment: Why Are Dual-Eligible Consumers in Los Angeles County Opting Out?

Kate McBride, Ana Reynoso, Tiffany Alunan, Brenda Gutierrez, Adrian Bacong, Marge Moon, Anastasia Bacigalupo, A.E. Benjamin, Steven P. Wallace, Kathryn G. Kietzman

SUMMARY: Los Angeles County has the state's lowest rate of consumer enrollment in Cal MediConnect, a program that is responsible for the delivery and coordination of medical, behavioral health, and long-term services and support benefits for individuals who are dually eligible for Medicare and Medi-Cal. This policy brief examines the factors that influence consumer decisions and may contribute to low enrollment rates. Influential factors include consumer knowledge of health care options,

perception of choice, and disruption of existing care. Differences in decision making by age, complexity of health care needs, race/ethnicity, immigration status, and primary language are also noted. Policy recommendations include engaging consumers in the planning and dissemination of information about their health care options, optimizing consumer choice and implementing the least disruptive pathway to enrollment, and recognizing and responding to the great diversity of dual-eligible consumers in Los Angeles County.

“Only 19 percent of the vulnerable Angelenos eligible for Cal MediConnect have enrolled.”

In the U.S., approximately 10.7 million people are eligible for both Medicare and Medicaid (Medi-Cal in California), including seniors with multiple chronic conditions and young people with significant disabilities.¹ There is considerable diversity within this population, with nearly 44 percent representing racial/ethnic minorities.² Dual-eligible individuals are among the poorest and sickest of health care consumers, and they account for a disproportionate share of utilization and spending in both Medicare and Medicaid.^{3,4} In 2012, dual-eligible beneficiaries accounted for 34 percent of total Medicare spending (\$187 billion) and 33 percent of total Medicaid spending (\$119 billion), even though they represent only 20 percent and 15 percent of the total Medicare and Medicaid populations, respectively.⁵

The multiple chronic conditions or disabilities among this high-need population, the fragmented delivery system, and the lack of coordination between Medicare and Medicaid often lead to gaps in access to care, care coordination, and continuity of services.⁶⁻⁸ The Affordable Care Act of 2010 established the Center for Medicare and Medicaid Innovation, with new authority to test innovative integrated payment and service delivery models that better align Medicare and Medicaid benefits.⁹ As part of this initiative, demonstration programs were established in 13 states, including California, to evaluate the effectiveness of integrating benefits for consumers.¹⁰ The primary goals are to improve access to essential services such as medical care, mental health care, social services, and long-term services and supports (LTSS); improve access to and utilization of home and community-based services; and enhance care coordination.

“There are significant language and racial/ethnic differences in Los Angeles County enrollment.”

Cal MediConnect: Enrollment Far Below Expectations

California’s demonstration program, Cal MediConnect (CMC), was launched in Los Angeles County in April 2014.¹¹ CMC is responsible for the delivery and coordination of medical, behavioral health, and LTSS benefits. All services are administered through managed care plans, many of which offer extra benefits such as care coordination, unlimited transportation to medical services, and additional vision or dental benefits.

The state adopted a “passive enrollment” process for CMC, meaning that consumers were automatically enrolled in the full managed care option unless they actively requested to keep their Medicare benefits excluded. Dual-eligible individuals received a series of 90-, 60-, and 30-day mailed notices in blue envelopes that asked them to either choose a CMC plan or opt out of the full program. Individuals 55 years of age or older had an option to apply for the Program of All-Inclusive Care for the Elderly (PACE).¹² If consumers did not provide a response by the deadline, they were automatically assigned to a CMC plan. If they chose to opt out, they could retain their Fee-for-Service (FFS) Medicare but still had to enroll in a Medi-Cal managed care plan for all of their Medi-Cal benefits, including LTSS. Enrolled consumers had the option of disenrolling from CMC or enrolling in one of the other CMC plans at any time, with change of coverage effective the first day of the following month.

Enrollment in CMC has fallen far below the expectations of the state and participating managed care plans. Opt-out rates are higher than anticipated, and a notable proportion of consumers disenroll within the first few months. While about 415,000 residents in the seven California demonstration counties are eligible to enroll in CMC, only 116,231 (28 percent) were enrolled as of June 2017.¹³ Enrollment rates range from a high of 71 percent in San Mateo County to a low of 19 percent in Los Angeles County, while the remaining five counties have enrollment rates

that fall between 32 percent and 45 percent. If Los Angeles County (home to nearly half of California’s CMC-eligible population) were excluded, the enrollment rate for the six remaining counties would be 39 percent.¹³

CMC in Los Angeles County: Low Enrollment, High Diversity

As noted, Los Angeles County has the lowest enrollment in the state, at 19 percent. Nearly 58 percent of Angelenos opted out of the plan, and 8 percent disenrolled. An additional 15 percent disenrolled from a CMC plan due to changes in Medi-Cal eligibility, enrollment in a Medicare Advantage plan, or other changes in Medicare eligibility.¹³

There are significant language and racial/ethnic differences in Los Angeles County enrollment. Individuals who speak Russian had a 94 percent opt-out rate, followed by Hebrew speakers (88 percent), Armenian and Farsi (82 percent), and Korean (78 percent). Racially/ethnically, Koreans (79 percent), Chinese (72 percent), Amerasian (72 percent), and Whites (72 percent) had the highest opt-out rates.¹⁴ Latinos/Hispanics were among the least likely to opt out (45 percent), followed by Samoans (36 percent).¹⁴

The CHOICE Study

Consumer Health Care Options: Investigating Cal MediConnect Enrollment

The CHOICE study was a two-year project that examined the decision-making processes of those eligible for Cal MediConnect in Los Angeles County. The study was conducted by the UCLA Center for Health Policy Research in partnership with the Westside Center for Independent Living and a Community Advisory Group of five consumers and five stakeholders.¹⁵ Findings are drawn from 53 in-depth, one-on-one interviews and six focus groups (36 participants) conducted with dual-eligible consumers. (For more information about the CHOICE study methods and participants, including individual and composite case studies, please visit <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1661>.)

People, Not Just Paper

Despite the multiple blue-envelope notifications, understanding of the CMC program varied greatly across both interview and focus group participants. Further, study data indicate that consumer knowledge about what health plan options were available to them was directly influenced by who delivered the information. Interview participants most frequently mentioned doctors and other personnel in doctors' offices as trusted information sources.

“No, I didn't understand that I could opt out of the CMC plan...or that I had any choices. Like if I could disenroll after a certain time, you know, I wasn't aware of that...I didn't do it on my own. I'm challenged in that area...so I spoke with a specialist in the doctor's office...she deals with billing and knows insurance...and she had been well-informed.”

– African-American female, 66,
who opted out of CMC

Family members, friends, and peers were the next most frequently mentioned source, followed by community-based organizations (most typically, through interactions with benefits specialists and case managers). Few immigrant consumers mentioned formal community-based resources for information.

Some information sources were more influential than others. This was especially the case among older adults, individuals with complex care needs, and monolingual Spanish-speaking participants, all of whom tended to most trust information that was provided by people with whom they had long-standing relationships—most commonly, medical providers, family members, or friends. Others stressed the importance of training health

care professionals and providers to be more knowledgeable about changing health care policies and practices so that they could better relay accurate information to consumers.

Interview and focus group participants also talked about their responses to the actual content they were provided about CMC. While many recalled receiving the blue CMC notification envelopes, most reported that the information they received was too dense, complicated, and confusing. Some participants reported that they never received the blue envelopes, while others said they ignored these notifications. Many were overwhelmed by having five different CMC health plan options (L.A. Care, CareMore, Care1st, Molina, and Health Net).

“Well, no one has time to read those books they send...a lot of information just to do what they want. So I don't read them, but I do ask [questions, at the community meeting].”

– Latina female, 80,
CMC enrollee
[Translated from Spanish]

Even consumers who had access to health plan and community organization supports often struggled to understand their options. Many consumers were unaware of the extra benefits offered by the CMC plans; others mistakenly believed that they might lose their current benefits if they did not enroll in CMC.

Perception of Choice

Some interviewees and focus group participants reported that they were very clear about their decision from the moment they received the first notification. This experience was most frequently noted by participants who had decided to opt out. Others, due to the passive enrollment process, experienced no choice when they were automatically enrolled.

“Knowledge about what health plan options were available to them was directly influenced by who delivered the information.”

“It wasn’t anything I chose to do, it was...because I...had applied for and was accepted for Medi-Cal... [They] put me in, and they just automatically told me I was in Cal MediConnect.”

– Filipino male, 83,
CMC enrollee

“Being able to maintain continuity of care was of great importance to virtually all study participants.”

Some consumers “discovered” that their care providers or services had changed when they were denied medical services, medical supplies, or prescription drugs. Many didn’t know who to contact to address these issues.

Participant reactions ranged across a spectrum, from those who were proactive and engaged in the process to those who were more passive and either deferred to the recommendations of others or simply did nothing. Within the immigrant subgroup, for example, most of the Latino participants did not raise questions about the new/additional services they would receive under their new health plan coverage or ask why these changes were taking place. Others, who were more engaged and appeared to be well informed, considered their options carefully and chose what they believed best met their health care needs. For example, while a good number of consumers acknowledged that extra benefits offered through some of the CMC plans were attractive, many were willing to forgo these advantages to remain with an existing and trusted network of care. This “weighing of options” was observed over and over again.

“It’s always a choice...What am I gaining? What am I losing? ... So I was being very concerned if I did any change, do I really know... Is it going to be better? Is it going to be worse?”

– Caucasian female, 68,
disenrolled from CMC

Finally, CMC’s status as a managed care plan was seen as a disadvantage by many, who voiced concerns that the pool of doctors and specialists in managed care plans is quite limited compared to FFS Medicare and that managed care plans usually impose more restrictions on services and benefits. These concerns were shared by both younger and older consumers who were averse to having someone else “manage” their care. In many cases, these consumers had not experienced managed care directly and were basing their opinions on what they had heard and on a general belief that managed care organizations typically provide a lower quality of care.

“Better quality and good plans won’t join Cal MediConnect... Because we’re low-income...we’re only confined to what certain doctors will permit...and, unfortunately, some—not all of them, but a lot of them—are not good quality.”

– Caucasian female, 64,
disenrolled from CMC

Disruption of Existing Care

Being able to maintain continuity of care was of great importance to virtually all study participants. The ability to maintain relationships with existing health care providers (primary care and/or specialists) as well as services or products (e.g., pharmacies, durable medical equipment, incontinence supplies, and transportation vendors) had a significant impact on decision making. Participants whose current primary care providers/specialists were already part of a CMC plan generally had no hesitation in enrolling, because they were able to maintain a familiar and trusted network of care. Conversely, consumers who knew they would lose their current care network by joining a CMC plan opted out.

“Now I’ve thought about some things...I got better referrals and equipment through MediConnect, but it was the primary doctor that was my main priority.”

– Caucasian female, 45,
disenrolled from CMC

In the current study, maintaining known and trusted providers was especially important to older adults with longer health histories and complex health conditions and to younger adults with disabilities. Other studies of Cal MediConnect have published similar findings.^{16, 17}

Policy Recommendations

In the current political context, there is uncertainty about the direction of health care financing and delivery in the United States, especially for the most vulnerable populations. Finding ways to empower dual-eligible consumers to better understand their health care options and to make informed choices within this context is critically important. Other states may learn from the California experience how to better coordinate and integrate initiatives to deliver medical, behavioral, and chronic care (e.g., Patient-Centered Medical Homes, Accountable Care Organizations) that are being advanced across the nation.¹⁸

Engage consumers in planning and disseminating information about health care options.

For many consumers, the complexity of information about CMC and other health care products is a barrier to informed decision making. Consumers should be supported in taking a more active role in how information is communicated to them. In this study, consumers expressed the desire to receive information from participating CMC health plans that more clearly explains how a plan will be responsive to their particular health

needs and geographic location. They also valued personal testimonials from current health plan consumers, made available in print for those without access to the internet. Information provided about new health care options must be available in multiple forms (visual, print, oral), available in the consumer’s primary language, and presented in plain language, which is especially important for those with limited health literacy.^{19, 20}

Health plans and community-based organizations should collaborate to train people who are identified by consumers as trusted sources to become health information navigators, using a model like Covered California’s Navigator Program.²¹ Training of health care and social service providers should also address potential conflicts of interest that may shape their views of CMC. Involving trusted community organizations that serve ethnic enclaves is especially important. Health care information that is delivered by a trusted source and in a culturally appropriate manner will facilitate consumer understanding of and access to the health care options that best meet their needs.

Optimize consumer choice and implement the least disruptive pathway to enrollment.

Perhaps the most commonly expressed interest of Cal MediConnect consumers is in preserving their existing network of care.^{16, 17} CMC’s passive enrollment process resulted in disruption for many consumers who were either unaware of or did not understand their options. Most older adults with multiple chronic conditions and younger people with lifelong disabilities have worked long and hard to cobble together a network of care that is responsive to their individual and complex needs and preferences.²² While CMC includes provisions for continuity of care (6 months for Medicare providers, 12 months for Medi-Cal providers), their fulfillment is dependent on providers who agree to work with them. Furthermore, these short-term arrangements do not substitute for the long-standing provider relationships that most consumers value.

“Consumers should be supported in taking a more active role in how information is communicated to them.”

Rather than disrupt the existing care networks of vulnerable health care consumers, California policymakers and planners might consider instituting a coordinating agency that works to streamline consumer care across *existing* providers and services. This is the approach of the integrated Managed Fee-for-Service (MFFS) demonstration program for dual-eligible individuals that is showing signs of success in Washington State.²³ Within this new model of care, consumers continue to have access to the same Medicare and Medicaid services and benefits and may also be connected to new services that fill current gaps in their care. Enrollees work with a personal care coordinator to help them develop and manage their comprehensive care plans. They also gain additional benefits through the Health Home, including transitional care services, mental health services, and referral to community supports and services.^{24, 25}

Recognize and respond to consumer diversity.

The racial/ethnic diversity of the dual-eligible population is projected to grow dramatically in coming years. While the current study had limited capacity for conducting interviews in multiple languages, the dramatic opt-out rates among certain ethnic and language groups in Los Angeles County and among consumers who were not U.S.-born strongly signal the need to more carefully examine the unique experiences and preferences of these consumers. The ability of immigrant consumers to make appropriate health care decisions may be challenged by limited English proficiency, lower levels of formal education, immigration status, and conditions in an immigrant's home country that may increase that individual's fear of government and government-initiated changes.^{26, 27, 28} Community organizations, especially those serving ethnic enclaves and immigrant communities, must dedicate extra attention to identifying and addressing these needs.

Funder Information

Support for this research was provided by the Robert Wood Johnson Foundation (grant #73052). The views expressed here do not necessarily reflect the views of the Foundation.

Author Information

Kate McBride, BA, is a doctoral student in the Department of Health Policy and Management, UCLA Fielding School of Public Health. Ana Reynoso is an undergraduate student at UCLA. Tiffany Alunan, BA, is a recent UCLA graduate. Brenda Gutierrez, BA, is an MPH student at California State University, Fullerton. Adrian Bacong, MPH, is a doctoral student in the Department of Community Health Sciences, UCLA Fielding School of Public Health. Marge Moon is a personal assistance specialist at the Westside Center for Independent Living in Los Angeles. Anastasia Bacigalupo, JD, is executive director of the Westside Center for Independent Living. A.E. Benjamin, PhD, is a professor emeritus in the Department of Social Welfare, UCLA School of Public Affairs. Steven P. Wallace, PhD, is a professor in the Department of Community Health Sciences, UCLA Fielding School of Public Health, and associate director of the UCLA Center for Health Policy Research. Kathryn G. Kietzman, PhD, is a research scientist at the UCLA Center for Health Policy Research and an assistant researcher in the Department of Community Health Sciences, UCLA Fielding School of Public Health.

Acknowledgments

We are grateful for our collaboration with the Westside Center for Independent Living and the Community Advisory Group that made this work possible. In particular, we acknowledge the important contributions of Zena Garcia, Kim Hudson, Michael Payne, Suzie Shapiro, and Brenda White (consumer advocates) and of Denny Chan of Justice in Aging, Rina Cruz of Care1st Health Plan, Janet Heinritz-Canterbury of the Personal Assistance Services Council of Los Angeles, Catherine Nicklen of the Center for Health Care Rights, and Erica Estrada-Szamet of L.A. Care Health Plan.

We also appreciate the thoughtful reviews of this policy brief that were provided by Denny Chan, Carrie Graham, Rosana Leos Bravo, Carolyn Mendez-Luck, and Anne Soon Choi.

“The dramatic opt-out rates among certain ethnic and language groups in Los Angeles County and among consumers who were not U.S.-born strongly signal the need to more carefully examine the unique experiences and preferences of these consumers.”

Suggested Citation

McBride K, Reynoso A, Alunan T, Gutierrez B, Bacong A, Moon M, Bacigalupo A, Benjamin AE, Wallace SP, Kietzman KG. 2017. *Cal MediConnect Enrollment: Why Are Dual-Eligible Consumers in Los Angeles County Opting Out?* Los Angeles, CA: UCLA Center for Health Policy Research.

Endnotes

- 1 Centers for Medicare and Medicaid Services. *Financial Alignment Initiative for Medicare-Medicaid Enrollees*. July 28, 2017 [cited 2017, Aug. 9]. Available at <https://innovation.cms.gov/initiatives/Financial-Alignment/>.
- 2 Community Catalyst, Inc. 2014. *Miles to Go: Progress on Addressing Racial and Ethnic Health Disparities in the Dual Eligible Demonstration Projects*. Available at <https://www.communitycatalyst.org/resources/publications/document/Miles-to-Go-Health-Disparities-in-the-Dual-Eligible-DemonstrationsFINAL.pdf>.
- 3 Musumeci M. August 2014. *One Year into Duals Demo Enrollment: Early Expectations Meet Reality*. Henry J. Kaiser Family Foundation. <http://www.kff.org/medicaid/perspective/one-year-into-duals-demo-enrollment-early-expectations-meet-reality/>
- 4 Young K, Garfield R, Musumeci M, Clemans-Cope L, Lawton E. 2013. *Medicaid's Role for Dual-Eligible Beneficiaries*. Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. Issue Brief. Retrieved from <http://www.kff.org/medicaid/issue-brief/medicaids-role-for-dual-eligible-beneficiaries/>.
- 5 Medicare-Medicaid Enrollee Information National. 2012. Available from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NationalProfile_2012.pdf.
- 6 Fox MH, Reichard A. 2014. Disability, Health, and Multiple Chronic Conditions Among People Eligible for Both Medicare and Medicaid, 2005 – 2010. *Prev Chronic Dis* 10(6):1-14.
- 7 Gimm G, Blodgett E, Zanwar P. 2016. Examining Access to Care for Younger vs. Older Dual-Eligible Adults Living in the Community. *Disabil Health J* 9(3):431-438. doi:10.1016/j.dhjo.2015.12.004
- 8 Sangeloty Higgins P, Shugrue N, Ruiz K, Robison J. 2015. Medicare and Medicaid Users Speak Out About Their Health Care: The Real, the Ideal, and How to Get There. *Popul Health Manag* 18(2):123-130. doi:10.1089/pop.2014.0056
- 9 About the Medicare-Medicaid Coordination Office. 2017. Available from <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/>.
- 10 Musumeci M. 2015. *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS*. Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. Issue Brief. Retrieved from <http://www.kff.org/medicaid/issue-brief/financial-and-administrative-alignment-demonstrations-for-dual-eligible-beneficiaries-compared-states-with-memoranda-of-understanding-approved-by-cms/>.
- 11 Information about Cal MediConnect can be found at <http://calduals.org>.
- 12 PACE: <https://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html>
- 13 Cal MediConnect Monthly Enrollment Dashboard (as of June 2017). Retrieved from <http://calduals.org/background/enrollment/statistics/>.
- 14 Cal MediConnect Monthly Enrollment Dashboard (as of October 2016). Available at <http://calduals.org/wp-content/uploads/2016/10/October-Enrollment-and-Detailed-Opt-Out-Dashboard-FINAL.pdf>. (Note: This October 2016 monthly enrollment summary was the last published state report to provide detailed opt-out information by language and race/ethnicity.)
- 15 The Community Advisory Group included consumers, providers, administrators, and advocates who guided all study activities, including development of data collection tools and recruitment materials, analysis and interpretation of data, and planning for dissemination of the most relevant findings.
- 16 Researchers from the University of California at San Francisco and Berkeley (UCSF/UCB) are engaged in a three-year evaluation (2015-2018) of the CMC program across all seven demonstration counties. Many of the findings from a series of 14 focus groups and 2000+ telephone surveys completed last year echo the findings of this study, which takes a more in-depth view of consumer experience and decision making in Los Angeles, the county with the lowest enrollment rate. Of particular note are consistent reports about the importance of maintaining continuity of care with both providers and services, particularly for those with complex chronic conditions and/or disabilities. Both CHOICE and UCSF/UCB survey participants also reported that notifications about CMC could have been improved, and that they found the enrollment letters mailed by the state to be confusing. See: Graham C, Kurtovich E, Liu M, Wong A, Tlatelpa K, Stewart H. 2016. *Evaluation of Cal MediConnect: Key Findings from Focus Groups with Beneficiaries*. Long Beach, CA: The SCAN Foundation. Available at http://www.thescanfoundation.org/sites/default/files/cal_medicconnect_key_findings_brief_march_2016.pdf.
- 17 Graham C, Liu P, Kaye S. 2016. *Evaluation of Cal MediConnect: Key Findings from a Survey with Beneficiaries*. Long Beach, CA: The SCAN Foundation. Available at http://www.thescanfoundation.org/sites/default/files/uc_duals_phonesurvey_2016.pdf.
- 18 Bechtel C, Ness DL. 2010. If You Build It, Will They Come? Designing Truly Patient-Centered Health Care. *Health Aff*. 29(5):914-20.
- 19 Danis M, Solomon M. 2013. Providers, Payers, the Community, and Patients Are All Obligated to Get Patient Activation and Engagement Ethically Right. *Health Aff* 32(2):401-7.
- 20 Nadash P, Day R. 2014. Consumer Choice in Health Insurance Exchanges: Can We Make It Work? *J Health Politics, Policy and Law* 39(1):209-35.
- 21 <http://bbex.coveredca.com/navigator-program/>
- 22 Kietzman KG, Durazo EM, Torres JM, Choi AS, Wallace SP. 2011. *Independence at Risk: Older Californians with Disabilities Struggle to Remain at Home as Public Supports Shrink*. Los Angeles, CA: UCLA Center for Health Policy Research.
- 23 Washington State Department of Social and Health Services, Washington Health Home Program. Available at <https://www.dshs.wa.gov/altsa/washington-health-home-program>. Note: In contrast to CMC's capitated demonstration model, in which California receives a prospective joint payment to provide enrolled duals coordinated care within a specific health plan, an MFFS model allows the state to benefit from savings resulting from initiatives to improve quality and reduce costs by coordinating care across existing providers. Washington's MFFS program also leverages resources through the state's Health Home program, which targets dual-eligible beneficiaries with chronic health conditions.
- 24 Clark W, Lehman D. 2016. *Measurement, Monitoring, and Evaluation of the Financial Alignment Initiative for Medicare-Medicaid Enrollees: Preliminary Findings from the Washington MFFS Demonstration*. Available at <https://innovation.cms.gov/Files/reports/fai-wa-prelimppone.pdf>.

10960 Wilshire Blvd., Suite 1550
Los Angeles, California 90024



The UCLA Center
for Health Policy Research
is part of the
UCLA Fielding School of Public Health.

The analyses, interpretations, conclusions,
and views expressed in this policy brief are
those of the authors and do not necessarily
represent the UCLA Center for Health Policy
Research, the Regents of the University
of California, or collaborating
organizations or funders.

PB2017-7

Copyright © 2017 by the Regents of the
University of California. All Rights Reserved.

Editor-in-Chief: Gerald F. Kominski, PhD

Phone: 310-794-0909
Fax: 310-794-2686
Email: chpr@ucla.edu
healthpolicy.ucla.edu



Read this publication online

- 25 Clark W, Lehman D, Brangan N. 2015. *Report on Early Implementation of Demonstrations under the Financial Alignment Initiative*. Available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf>.
- 26 Johnson KR. 1995. Public Benefits and Immigration: The Intersection of Immigration Status, Ethnicity, Gender, and Class. *Immigration and Nationality Law Rev* 17:457.
- 27 Derose KP, Escarce JJ, Lurie N. 2007. Immigrants and Health Care: Sources of Vulnerability. *Health Aff* 26(5):1258-68.
- 28 Ponce NA, Ku L, Cunningham WE, Brown ER. 2006. Language Barriers to Health Care Access Among Medicare Beneficiaries. *Inquiry: A Journal of Health Care Organization, Provision, and Financing* 43(1):66-76.