

The CHOICE Study: A Case Study of Consumers Who Disenrolled

Read the related study:

Cal MediConnect Enrollment: Why Are Dual-Eligible Consumers in Los Angeles County Opting Out?
<http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1661>

Introduction

Under California's Coordinated Care Initiative, enrollment into Cal MediConnect (CMC) was achieved either through active enrollment into a CMC plan or through a passive enrollment process. Passive enrollment occurred if a dual eligible consumer did not make the choice; he or she was then automatically enrolled into a CMC plan. These consumers remained in CMC unless they actively disenrolled from the CMC plan.

As of August 2017, approximately 8 percent of CMC enrollees in Los Angeles County disenrolled through the State's enrollment broker after the enrollment effective date. This percentage does not include disenrollment due to changes in Medi-Cal or Medicare eligibility. In other CMC counties within California, disenrollee opt out rates ranged from 3-11 percent.

The CHOICE Study interviewed a total of 53 dual eligible beneficiaries: 7 had disenrolled from CMC. This group of consumers ranged in age from 45 to 93 years old. One had remained in a CMC plan for about one year, while the other 6 had been in the program for a period of 3 to 6 months. More details about the experiences of disenrolled and other types of consumers are presented in individual case studies (see related study link above). We examine and compare the decision-making experiences of these consumers in the context of three specific themes: knowledge of healthcare options, perception of choice, and disruption of care.

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Knowledge of Health Care Options

Two of the seven consumers who disenrolled had actively joined a Cal MediConnect (CMC) plan and later decided to dis-enroll. These participants acknowledged that they were aware of their health plan options throughout the enrollment process, and chose the best option for their health care needs. One said, "I knew I had choices to make, so I pursued each route to find out which one I needed to take."

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The other 5 consumers who disenrolled explained that they never received notices about CMC, and were informed of their enrollment months after CMC went into effect. They often found out about their CMC enrollment status when they were denied medical services, medical supplies, or prescription drugs. The unexpected enrollment sometimes resulted in delayed access to much needed care and assistance until the authorization issues were resolved. One consumer shared his frustration: "It took time to get disenrolled ... It upset my drug prescription plan. I had to call them to re-enroll and then all my medications that were exemptions had to get the doctors [authorization] ... I had to go through that whole process again ... it created a lot of problems."

Even after they discovered they were passively enrolled in CMC, these consumers remained confused about their health care options. One stated, "No, I didn't understand that I could opt out of that [CMC plan they enrolled me in]. No I didn't really know that I had choices ... or if I could dis-enroll after a certain time..." Most were not aware that they had the option to disenroll from CMC at any time, for any reason.

Information Sources

Once they discovered they were enrolled, these consumers found that the available information sources (i.e. websites, hotlines, CMC plan representatives) were difficult to use. For instance, those who called CMC hotlines sometimes found themselves speaking with representatives who had limited knowledge. One participant noted that rather speak to someone from the CMC hotline, he relied primarily on "the health care agencies, because they're the ones that have all the information ... but [sometimes] I would find out they weren't really connected or I got misinformation."

Another participant recalled receiving misinformation while he tried to determine if he could maintain continuity of care with his primary care doctor: "Yeah, I had

people [health care representatives] say, "If you enroll with us, you can go there and see [that doctor]." It wasn't true. I've been to five different representatives before I could get back on straight."

While some consumers were successful in finding information regarding their transition to CMC from community-based organizations — typically from benefits specialists and case managers — most remained confused. Common concerns surrounding CMC included how it differed from their previous health care plan and why they had to find a new primary care doctor within the CMC network.

Who Can I Trust?

When deciding which health plan would be best for their particular health care needs, consumers also noted having difficulty trusting advice offered by CMC health plan representatives: "My first reaction was, well, why are they saying this? Is it that bad? Or is it that good? Does this person have a vested interest? ... will it have any negative impact on me?"

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Reflecting on challenges experienced when trying to find information about co-payments for prescription drugs and other services, one participant noted, "You don't know who to believe. You don't know who to trust. You don't know what's going to happen when you go in for that appointment."

The lack of communication and misinformation was particularly disruptive for disenrolled participants, most of whom had been passively enrolled into a CMC plan without their knowledge. This process caused a major disruption to their ongoing health care services and relationships with primary care doctors and spe-

cialists. After discovering that they were enrolled in CMC, many participants actively sought out information from community-based organizations and representatives in order to dis-enroll from the program. Ultimately, participants wanted to be the primary decision-makers for their health care.

Perception of Choice

Participants' perceptions of choice were influenced by both the CMC passive enrollment process and by their past experiences in the health care marketplace as dual-eligible consumers. Some felt that their choice in guiding and directing their care was inherently limited. They further believed that they received lower quality of care as a result of their socioeconomic status. Some consumers suggested that higher quality doctors and health care facilities would be unwilling to work with a CMC plan because they primarily serve low-income populations. One participant felt that finding a health

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care doctor suited to her particular health care needs and background was inherently limited because of her socioeconomic status: "Better quality and good plans won't join Cal MediConnect ... because we're low income ... a lot of them are not good quality and they're not somebody that I can relate to..."

These consumers further noted that they would have considered staying in the CMC plan if it offered "more high-quality plans and doctors." For example, one consumer had difficulty finding a new primary care doctor in the CMC network. "I tried two new primary doctors and I didn't like either one of them ... it didn't seem real clean, that kind of a thing ... I just didn't feel it or feel comfortable."

During the brief time they were enrolled in a CMC plan, consumers noted that they had fewer choices in their selection of specialty services and providers, and experienced constraints in access to health care services: "The choices were a little limited in specialists ... and you do need to have a referral for everything."

Most consumers expressed that their options in doctors and specialty services were expanded following dis-enrollment from their CMC plan. They felt they have more freedom now to choose which doctors they want to see without worrying about a referral to a specialist or other health care service being denied by CMC.

Knowledge of Extra Benefits

The decision to dis-enroll involved weighing the extra benefits of CMC (such as transportation, dental, and durable medical equipment) against the loss of primary care doctors and specialists. Although some participants acknowledged the advantages of additional services in CMC, this was not as high a priority as was staying with their current doctors and specialists. One participant received better medical equipment and lower out-of-pocket costs for her specific condition; however, continued care with her primary care doctor was a higher priority. "I was comfortable with making that decision [to dis-enroll] ... I think I got better referrals and equipment through MediConnect, but it was the primary doctor that was [my priority]..." This participant, along with other dis-enrollees, said they would have considered rejoining CMC if their doctors were also part of the plan. For these participants, remaining with their trusted doctors who had extensive knowledge of their medical history was the most important factor in their decision-making process.

While another participant acknowledged that the additional services offered by CMC plans were a benefit, she felt she had to carefully weigh her options. She was most concerned about what she might lose if she opted out of CMC. "It's always a choice but it's just the

easier. What am I gaining? What am I losing? And to me those are the important things ... Is it going to be better? Is it going to be worse?"

Fee-for-Service (FFS) vs. Managed Care (MC)

Some participants mentioned that they simply preferred their previous Medicare and Medicaid fee-for-service benefits. They felt that having these separate benefits provided them with more options and greater flexibility in their health plans and services.

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The association of CMC with managed care played a role in deterring some consumers from remaining enrolled in CMC. In some cases, it was the consumer's distrust of managed care that most influenced their decision-making process. One participant noted that Medicare and Medicaid representatives had actually encouraged his dis-enrollment from CMC: "They [the people who helped me dis-enroll] were actually in Medicare-Medi-Cal, as professionals ... maybe ... what helped me... [was] when they told me, 'Do not enroll in an HMO.'"

Much of this distrust in managed care plans (also referred to as Health Maintenance Organizations or HMOs) stems from experiences that they or their friends and family members had when previously enrolled in a managed care plan. One participant stated that some of her acquaintances, who are also dual eligible beneficiaries, told her not to remain with CMC *because* it was an HMO.

Disruption of Existing Care

Continuity with Primary Care Providers, Specialists

Although all dual eligible beneficiaries enrolled in CMC are allowed to keep seeing their existing doctors and maintain service authorizations for a period of up to 6 months for Medicare services and up to 12 months for Medi-Cal services, many were either unaware of this

option, or did not want to go through the process of finding a new primary care doctor in the CMC network.

One participant learned of her enrollment in CMC when she called to make a primary care appointment at her local clinic. "They told me, 'Oh, you're not covered.' And so that was startling. Then that's what started me on the road of phone calls to find out what was going on and I found I was switched from [original Medicare]to [Cal]MediConnect." This participant remained enrolled in the CMC plan for four months, however she then decided to dis-enroll following difficulties in finding a new primary care provider. Ultimately this participant felt her care had been disrupted by the abrupt changes made to ongoing health care management with her previous PCP. "That's why I wanted to go back to mine. Because when I go to [my doctor], ... she knows what the history is pretty much without even looking in the chart."

After becoming familiar with a service and/or specialist, many participants were uncomfortable with making any changes, particularly if they believed they were receiving high quality care from a leading facility.

Loss of Specialized Services

Another reason given for the decision to dis-enroll was the loss of specialized healthcare services (i.e. therapeutic, psychiatric services). For example, participants were frustrated when they learned that what they considered to be "leading medical institutions" (e.g., highly-ranked academic health science centers or university-based teaching hospitals) were not contracted with CMC. These consumers instead had to seek specialized services with a CMC-contracted health care facility. "It [enrollment in Cal MediConnect] just completely took me out of my health insurance into another one that didn't ... allow me to keep some of the things I wanted." After becoming familiar with a ser-

vice and/or specialist, many participants were uncomfortable with making any changes, particularly if they believed they were receiving high quality care from a leading facility.

While among this group of consumers the loss of primary care doctors or services was the primary reason for dis-enrollment, one individual dis-enrolled because her doctor was no longer affiliated with CMC. She initially enrolled in CMC because her doctor was affiliated with a CMC plan. However, a year after enrollment, when informed by her provider that he was no longer contracted with CMC, she dis-enrolled specifically because she wanted to remain with her doctor.

Conclusion

CMC's passive enrollment process disrupted existing care for most of these dual-eligible consumers. Loss of long-established relationships with primary care doctors and specialists was the primary factor that guided their decisions to dis-enroll. Many had been with their doctors for several years, and when they discovered that their providers were not part of CMC, they immediately knew that they would dis-enroll from the plan. Continuity of care was their highest priority.

All of the dis-enrolled participants in this case study expressed that information about Cal MediConnect was poorly communicated. As a result, they were confused about their health care options and the enrollment process caused a major disruption to their ongoing health care services.

When consumers were transferred into a new health plan without their knowledge or explicit consent, many became aware of the change when they tried to obtain needed prescription medication, make a routine doctor's appointment, or received a medical bill in

the mail. Most of these consumers reported that they never received the mailed CMC notifications and were not familiar with the term "Cal MediConnect" until they learned of their enrollment.

All of the dis-enrolled participants in this case study expressed that information about Cal MediConnect was poorly communicated. As a result, they were confused about their health care options and the enrollment process caused a major disruption to their ongoing health care services. Better communication strategies need to be developed to more effectively reach all dual-eligible consumers who need to make decisions about their health care plan/or services. Changes made to their existing networks of care can have serious implications for their health care outcomes and overall well-being.

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. 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>

Endnote

1. Cal MediConnect Monthly Enrollment Dashboard: As of August 1, 2017. <http://calduals.org/wp-content/uploads/2017/09/August-2017-CMC-Enrollment-Dashboard.pdf>