March 2, 2023

Focus Group Findings: Experiences of Full-Benefit Dually Eligible Beneficiaries in Integrated Care Models

Tamara Huson and Kirstin Blom

MACPAC

Medicaid and CHIP Payment and Access Commission

@macpacgov

www.macpac.gov

Overview

- Background
- Methodology
- Key themes
  - Enrollment experiences
  - Access to providers
  - Care coordination
  - Coverage of additional benefits
  - Experiences resolving issues with health plans
  - Overall satisfaction with integrated care
- Conclusions

Background

Background

- In 2020, 12.2 million individuals were enrolled in both Medicaid and Medicare
- For dually eligible beneficiaries, Medicare is the primary payer for acute and post-acute care services, while Medicaid is the secondary payer and wraps around Medicare
  - The division of coverage between the two programs can result in fragmented care and lack of coordination creates opportunities for cost shifting between the two programs

Background, cont.

- Integrated care is intended to better align delivery, payment, and administration of Medicaid and Medicare services, which in turn may improve care for dually eligible beneficiaries, eliminate incentives for cost shifting, reduce spending that may arise from duplication of services or poor care coordination, and promote equity
- As of 2020, just over 1 million full-benefit dually eligible beneficiaries received care through highly integrated models

Integrated Care Models

- Integrated care models offer varying degrees of clinical and administrative integration, including:
  - Medicare-Medicaid plans (MMPs) provide a high level of integration because all services are provided by a single plan
  - Dual eligible special needs plans (D-SNPs) provide Medicare coverage and may coordinate or cover Medicaid benefits depending on the type of D-SNP
    - Coordination-only D-SNPs (CO D-SNPs) provide minimal levels of integration through coordination of Medicaid services
    - Highly integrated dual eligible special needs plans (HIDE SNPs) and fully integrated dual eligible special needs plans (FIDE SNPs) cover some or all Medicaid services and typically provide a higher level of integration
  - Managed fee-for service (FFS) is used in one state, Washington, which leverages health homes to provide a higher level of integrated care

Methodology

Methodology

- MACPAC contracted with NORC at the University of Chicago to conduct focus groups with full-benefit dually eligible beneficiaries enrolled in integrated care in five states
- Ten focus groups were conducted virtually between November 2022 and January 2023
  - One focus group was held in Spanish
  - Due to challenges recruiting focus group participants, NORC also conducted 15 in-depth individual interviews

State Selection

States	Plan types					State population (millions)	Rurality[1]
	FIDE SNP	HIDE SNP	MMP	Managed FFS	CO D-SNP		
Nebraska		X			X	2.0	34.9%
New York	X	X	X[2]		X	19.8	7.0
South Carolina			X		X	5.2	14.5
Texas		X	X		X	29.5	10.8
Washington		X		X	X	7.7	10.2

Notes: FIDE SNP is fully integrated dual eligible special needs plan. HIDE SNP is highly integrated dual eligible special needs plan. MMP is Medicare-Medicaid plan. FFS is fee-for-service. CO D-SNP is coordination-only dual eligible special needs plan.

[1] Rurality is defined as the percentage of state residents living in nonmetro areas.

[2] In New York, the MMP is the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities program.

Sources: Rakich 2021, RHIhub 2022, U.S. Census Bureau 2022.

Focus Group Design

- Our focus group design included a comparison group to assess how beneficiaries' experiences enrolled in plans with higher levels of integrated care compared to those enrolled in plans with lower levels of integrated care
  - Plans with higher levels of integration: FIDE SNPs, HIDE SNPs, MMPs, and managed FFS
  - Plans with lower levels of integration: CO D-SNPs
- Twenty-one participants were enrolled in CO D-SNPs, and 34 participants were enrolled in plans with higher levels of integration

Participant Demographics

State and plan type	Total	Sex		Age					Urban/Rural[1]		Race/Ethnicity[2]			
	Count	Male	Female	18-30	31-44	45-54	55-64	65+	Urban	Rural	Hispanic	White, non-Hispanic	Black, non-Hispanic	Other
Total	**55**	**22**	**33**	**4**	**10**	**10**	**9**	**22**	**48**	**7**	**6**	**29**	**16**	**4**
Nebraska HIDE SNP	4	0	4	0	0	1	1	2	4	0	0	4	0	0
New York FIDA-IDD	7	3	4	1	3	2	0	1	7	0	0	6	1	0
New York CO D-SNP	4	3	1	0	2	0	0	2	3	1	0	3	1	0
New York HIDE SNP, FIDE SNP, and MMP	5	3	2	1	1	0	1	2	5	0	0	3	2	0
South Carolina CO D-SNP (2 focus groups)	11	2	9	1	0	4	4	2	9	2	0	4	5	2[3]
Texas CO D-SNP	4	2	2	0	1	0	1	2	2	2	0	2	2	0
Texas HIDE SNP and MMP	6	2	4	1	0	1	1	3	5	1	1	1	4	0
Washington Managed FFS	9	6	3	0	1	0	1	7	8	1	0	6	1	2[4]
New York Spanish Language	5	1	4	0	2	2	0	1	5	0	5	0	0	0

Notes: HIDE SNP is highly integrated dual eligible special needs plan. FIDA-IDD is Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities. CO D-SNP is coordination only dual eligible special needs plan. FIDE SNP is fully integrated dual eligible special needs plan. MMP is Medicare-Medicaid plan. FFS is fee-for-service.

[1] Participants were identified as urban or rural using data from the Federal Office of Rural Health Policy which uses Rural-Urban Commuting Area codes to define census tracts as either urban or rural and the Rural Health Information Hub's "Am I Rural?" tool.

[2] No study participants reported as Asian.

[3] Reported as mixed race, including Black, white, and Hispanic.

[4] Reported as mixed race, including white and Native American.

Key Themes

Enrollment Experiences

- Participants described taking various approaches to choosing their plan and receiving assistance from different sources, however, there were no noticeable differences between those in higher and lower levels of integration. Information sources included:
  - Family and friends
  - Internet research
  - Brokers
  - Targeted information sessions
- Participants commonly cited the ability to keep their primary care provider, access to specialists, or health system, as well as costs, as the most important factors in choosing a plan

“I was, first of all, looking for cost. And the second thing I was looking for was the hospital. Because I lived in [town] at the time, and, you know, like, there are hospitals in certain areas and things like that. So, I was really looking for what hospitals and doctors were covered and for the prescription amounts and what they were covered. And the [plan name] plans fit best into what I needed and was looking for at that time.”

- A participant from South Carolina in a CO D-SNP

Access to Providers

- Most of what we heard from participants about access was focused on Medicare-covered services such as primary care, urgent care, and specialty care
- For the most part, study participants did not report issues accessing primary care
  - Most participants reported having a primary care provider (PCP) and liking their PCP
- Many participants also relied on urgent care and described the importance of urgent care providers, finding it to be a convenient option

“I have a great relationship with [the PCP] now. She actually calls me herself. She doesn’t have the nurse calling or whatever. And I don’t have a problem getting an appointment. If I need an appointment the same day, I’m able to get in. So that makes a big difference.”

- A participant from New York serving as a caregiver of a beneficiary in a plan with a high level of integration

“I just wanted urgent care because... I wouldn’t have been able to get an appointment with my doctor because he has an office in [town 1] and [town 2], and he is only in [town 1] two days a week. So I would have to go to [town 2]. So it was easier for me to just walk up the block and go to the urgent care place.”

- A participant from New York in a CO D-SNP

Access to Providers

- Most focus group participants reported seeing specialists, with no appreciable differences among participants in the different types of integrated plans
  - Most participants did not have difficulty finding specialists accepting new patients but many had long wait times for initial appointments
  - Once established, participants largely described regular appointments and sufficient access
  - Participants in rural areas reported challenges due to lack of local specialists and transportation barriers
- Participants with mental health care needs experienced challenges accessing providers, regardless of plan type, including a lack of local providers, high turnover of providers, and long wait times

“Before the pandemic, I had the psychologist, then after that I didn't, because the psychologist left that place, and they didn't take my insurance, and it's a little bit difficult to find someone to take my insurance and close to where I live, because they always send me to [town]. Sometimes they want to give me the appointment in the afternoon, and I can’t [go] because I have a child, so all my appointments are mostly nine in the morning that I want to see them and they don't, they don't have that schedule, or they don't take my insurance.”

- A Spanish-speaking participant from New York in a CO D-SNP

Care Coordination

- Overall, about half of focus group participants reported having a care coordinator, but variation existed by state and plan type
  - For example, all of the participants in the New York FIDA-IDD demonstration and in Washington had care coordinators
  - For individuals enrolled in CO D-SNPs, less than half of those in South Carolina reported having a care coordinator, while about half in Texas and New York did
- Participants had mixed experiences with care coordination and few reported having a formal care plan
  - Many participants noted frequent turnover of care coordinators and did not feel like they were getting much value out of the service
  - Participants in New York's FIDA-IDD and in Washington reported positive and robust relationships with their care coordinators and had care plans that they revisited regularly and contained goals related to their health
  - Only two participants enrolled in CO D-SNPs reported having a care plan with established goals

“Having a care coordinator who was also running the life plan meetings [is a key benefit]. They seem to really want to do the right thing. They want to be there. They want to ask the hard questions so we can work things out. The care coordinator is a key advocate.”

- A participant from New York serving as a caregiver of a beneficiary in a plan with a high level of integration

Coverage of Medicaid Benefits

- A few caregivers and participants described receiving home- and community-based services (HCBS), as well as rehabilitation services after a hospitalization, and the importance of these services
  - A few participants noted challenges, such as high turnover of home health aides
  - Those in New York's FIDA-IDD demonstration emphasized the plan's care coordination of HCBS as a strength of the plan
- Participants reported mixed experiences with transportation benefits
  - Generally people were grateful for the benefit
  - Several people noted extended wait times or long travel times

“The residential services, employment, and vocational rehabilitation services that Medicaid provides in community living settings are very lacking. So, if my son were to go to a group home, he could only access the services in that group home. He couldn’t make his own independent choice for services right now. And if he went to an apartment, his Medicaid-supported waiver in South Carolina, would pay for eight hours of support a month. So, there is no way right now that he could live independently right now in South Carolina. Adults with severe disabilities require 24/7 supervision in community settings, and there’s no support.”

- A participant from South Carolina serving as a caregiver of a beneficiary in a CO D-SNP

“Our car broke down and it was a very expensive repair, so we had to start using the transportation. That’s been a lifesaver because he’s immunocompromised, I’m immunocompromised, and it’s not safe for us to go on the bus or train or anything, and it would take three bus rides, a train, and an Uber just to get to the doctors.”

- A participant from Texas in a CO D-SNP

Experiences Resolving Issues with Health Plans

- Experiences resolving issues with health care coverage largely centered around contacting their plan via the customer service line
- All of the participants in the Spanish-speaking group said that their plans offered assistance in Spanish, with one person noting there could be long wait times
- The majority of focus group participants were unfamiliar with the role of ombudsman in health care
- Focus group participants also had limited understanding of the appeals and grievances processes
- Some participants reported receiving unexpected medical bills, and working with either their provider or their plan to resolve it

“I have [heard of an ombudsman]. But it wasn’t in reference to any insurance issues. It was in reference to a nursing home issue for my dad.”

- A participant from South Carolina in a CO D-SNP

Overall Satisfaction with Integrated Care

- Most attendees were generally satisfied with their health care coverage
  - Most participants did not report any unmet needs. Those that did reiterated points they had made prior such as a lack of mental health providers.
  - Of the participants who reported unmet needs, more of this subset of individuals were enrolled in higher levels of integrated care
- While most participants rated their plans highly, those in highly integrated plans rated their plans slightly lower than those in the CO D-SNPs. Most participants in CO D-SNPs rated their health plan between a four and five (out of five) whereas the majority of participants in higher levels of integrated coverage gave their plans between a three and a five.

“I say five. I love my plan.”

- A participant from South Carolina in a CO D-SNP

.....

“Three because their network is very limited with the doctors that I want to see or have seen in the past. I don’t understand why the insurances, all these doctors, why are they always in different networks? Once you get with a doctor, you want to keep the doctor and it’s not in your network. Their network is limited to me.”

- A participant from Texas in a plan with a high level of integration

Conclusions

Conclusions

- Study participants were largely satisfied with their integrated coverage and able to access the care they need
- We did not generally hear meaningful differences between the experiences of dually eligible beneficiaries in plans with higher and lower levels of integration
  - One exception was those with higher levels of integration were more likely to have a relationship with their care coordinator and a care plan
- A number of participants noted challenges accessing services that are primarily covered by Medicaid, including behavioral health, HCBS, and transportation

Conclusions, cont.

- The findings from this work provide additional evidence for the importance of integrated care in successfully meeting the needs of dually eligible beneficiaries, as well as the role of states in oversight and monitoring of integrated products and ensuring beneficiaries have sufficient access to Medicaid services

- A summary of the focus group findings will be included in a descriptive chapter on integrated care in the June report to Congress

March 2, 2023

Focus Group Findings: Experiences of Full-Benefit Dually Eligible Beneficiaries in Integrated Care Models

Tamara Huson and Kirstin Blom

MACPAC

Medicaid and CHIP Payment and Access Commission

@macpacgov

www.macpac.gov