

**MICHIGAN MI HEALTH LINK  
BENEFICIARY EXPERIENCE CONSUMER  
FOCUS GROUPS AND INTERVIEWS**

**EXECUTIVE SUMMARY OF KEY FINDINGS**

This summary provides an overview of the results of qualitative research regarding the experience of MI Health Link beneficiaries which was conducted by Alan Newman Research on behalf of the Centers for Medicare & Medicaid Services (CMS) in June of 2019.

The overall objective of this research was to better understand the beneficiary experience in the MI Health Link demonstration in Michigan. In Michigan, three target audience segments were queried, including Medicare-Medicaid Plan (MMP)/MI Health Link enrollees who:

- Make use of Long-Term Services and Supports (LTSS)
- Make use of Behavioral Health (BH) services
- Have many different characteristics but do not use LTSS or BH services (referred to as “General” enrollees for the purposes of this research)

Participants were recruited for this research from lists of MI Health Link plan enrollees provided by the state. A total of 66 participants were queried across all groups. Of the 66 participants, 14 were LTSS, 10 were BH, and 42 were General. In addition to current enrollment in a participating MI Health Link plan, participants represented mixes of the following: MI Health Link plan membership, MI Health Link enrollment duration, health conditions, gender, age, education, and ethnicity.

In order to accomplish the research objectives, eight in-person focus groups and twelve telephone in-depth interviews (IDIs) were conducted in Michigan. The research was conducted in three markets – Detroit, Kalamazoo, and the Upper Peninsula. In the Upper Peninsula, telephone IDIs were conducted instead of focus groups.

**Satisfaction with MI Health Link**

**Overall, participants reported very high satisfaction with their MI Health Link plan experiences. This was true in Detroit, Kalamazoo, and the Upper Peninsula as well as across all three segments – General, LTSS, and BH.** They rated their satisfaction on a scale of 1 to 5 (where 1 was *Not at all Satisfied* and 5 was *Very Satisfied*) – the vast majority rated theirs a 4 or 5. In addition to their high satisfaction ratings, the tone and content of their comments as they discussed their plan experiences were usually very positive. Almost no participants reported ever having a problem getting services or health care when they needed them.

**Key reasons for participants' high satisfaction with MI Health Link included the following**

- Access to quality health care providers, as well as additional benefits and services (e.g., dental, vision, behavioral health, transportation, health clubs, home modifications, health club memberships, etc.)
- Care coordination / care coordinators who help get their needs met
- Free over-the-counter medical supplies (bandages, incontinence pads, etc.)
- Full coverage for their medical care and most prescription drugs (no costs, including no copays)
- General peace of mind, reduction of health and financial anxiety

**Factors that diminished participants' satisfaction included the following, which were mentioned primarily in Detroit and Kalamazoo (but not in the Upper Peninsula):**

- Delayed access to care or prescriptions due to required pre-authorizations
- High turnover among care coordinators
- Limited dental coverage
- Negative experiences with non-emergency transportation services [e.g., lateness, long pick-up/drop-off windows) (Detroit only) and three-day lead time to schedule a ride (Detroit and Kalamazoo)]
- Non-coverage of certain prescriptions or treatments

**Initial Information about MI Health Link**

**Most participants learned about MI Health Link via a letter “from DHS” - i.e., the Michigan Department of Health & Human Services.** Other initial sources of information included a phone call (from unrecalled sources), professionals in support roles, a health care provider, or friends and family who already had this coverage.

**Care Coordination in MI Health Link Plans**

**Many participants reported that the coordination of their care had multiple influences – both personal (self, family, friends) and external (doctors, care coordinators, and sometimes other professionals).**

**However, the vast majority of participants reported with certainty that they had a care coordinator through their MI Health Link plan - and most were quite positive about theirs.** A few either reported that they did not currently have a care coordinator - or they were not sure.

**For most of those who had one, the care coordinator played a definite, memorable role in their lives.** Participants almost always 1) knew who he or she was and 2) recognized that having a care coordinator was a benefit of being in the plan.

**Participants were usually very positive about their experiences with their plan care coordinator.** The majority had a care coordinator and heard from him/her regularly – most often by phone, but sometimes via home visit (in Detroit and Kalamazoo, but not in the Upper Peninsula). Care coordinators’ frequency of contact and intensity of involvement depended on participants’ level of need. Compared to most General participants, LTSS and some BH participants described the closest relationships with their care coordinators.

**While most reported satisfaction with their current care coordinator, a very few were less satisfied due to the following:** delays in returning calls, lack of follow-through on requests, youth/lack of experience, and too much or not enough contact.

**Participants described how their care coordinators help them with their care.** Consistently, the following were mentioned:

- Assessment of initial (at time of enrollment) and ongoing needs
- Assessment of potential needs for in-home and personal care services
- Assistance during care transitions
- Follow-up after doctors’ appointments (and attendance at appointments, in a few cases)
- General emotional support
- Location of health care and service providers who accept the plan (providing lists, calling to set up appointments in a few cases)
- Medication management
- Offering of services that are available (even if these are declined, enrollee awareness is established, enrollee feels supported)
- Regular check-ins, usually by phone and sometimes in the home
- Reminders and encouragement to seek needed medical care and keep appointments

**In Detroit and Kalamazoo, participants reported that care coordinator turnover is relatively common, which they disliked and usually found disruptive.** In contrast, Upper Peninsula participants did not report frequent turnover - they had usually had the same care coordinator since one was assigned to them.

**The vast majority of participants was satisfied with the amount of contact they had with their care coordinators – i.e., they characterized it as “enough.”** However, a few said they were contacted too often, while a very few would like more contact from a care coordinator.

**Participants reported having no specific expectations of their care coordinator prior to working with one. In fact, in some cases, they were surprised to be contacted by one and even suspicious of their calls.** A few specifically said they would have liked more explanation from the plan – at the time of enrollment - about what to expect from a care coordinator. Ultimately, for most, the care coordinator experience exceeded what they expected from an insurance provider.

**Without exception, participants said they could contact their care coordinators easily, and most had a direct phone number for theirs.** Most participants were called regularly by their care coordinators, at a frequency ranging from monthly to every three or six months, and sometimes more often, depending on level of need.

**Selected areas of care coordinator involvement were explored, including the following (presented here in order of special beneficiary interest):**

- **Care transitions.** Several higher-need LTSS and BH participants had experienced care transitions, while only a few in the General segment had. Almost always, these were hospital-to-home transitions, although a very few had gone from the hospital to a rehabilitation center or skilled nursing facility first.

The extent of care coordinator involvement during care transitions seemed dependent on level of need. Higher-need participants' very involved care coordinators typically did support them at multiple points during these transitions. For example, according to one, *"When I had to go have surgery, she was there [in the hospital] all the way through, and then afterwards, she was there. She came to my house, set up all appointments, she did everything"* (LTSS, Detroit).

However, only a few of the lower-need participants (typically in the General segment) had experienced hands-on care coordinator support, while the rest had either relied on hospital and family assistance or had not needed help.

- **Coordinating with providers.** Most participants were not well aware of if or how their plan care coordinator worked with their providers or any other agencies that were involved in their care. If this was occurring, it seemed to be "behind the scenes" and not easily apparent to them. None described any problems or difficulties associated with care coordinators' collaboration with other support people in their lives.
- **Inappropriate billing.** Participants reported minimal billing issues since their plan enrollment - they had not needed much help from care coordinators in this regard. A very few had received bills, and usually they had resolved them on their own with a call to the provider or the plan. A very few had involved their care coordinators, who resolved the issue. Participants were universally aware that they had a zero-dollar copay, and many knew that this was printed on their card. Only a very few had ever needed to use the card's message to prove they had no copay, including one in Detroit who showed it at a pharmacy.

- **Appointments.** Higher-need participants who had close relationships with their care coordinators reported the most consistent follow-up about their doctors' appointments. A few in Detroit and Kalamazoo also said their coordinator had gone with them to medical appointments or had offered to do so.
- **Communication with service providers (transportation, medical equipment, etc.).** Participants said their care coordinators had informed them about services they could get and provided them with lists of participating service providers. Most knew (and felt confident) that their care coordinator would get involved in finding or communicating with these service providers if needed. Some higher-need participants had gotten help from care coordinators in this regard, while more self-sufficient participants did so on their own.
- **In-home and personal care services.** Almost without exception, due to care coordinator communication, participants knew that in-home or personal care services were available to them if needed. Most in the General and BH segment did not use these currently, while among LTSS beneficiaries, virtually all were using services like these.

### **Individual Integrated Care and Support Plan**

**The vast majority of participants reported having an Individual Integrated Care and Support Plan (“care plan”) which accurately summarized the needs and goals they had discussed with their care coordinators.** Attitudes about care plans ranged from enthusiasm to indifference, depending on the individual. Participants queried represented a mix of those who were highly, moderately, and not at all engaged with their care plans.

Participants who self-identified as “goal-oriented” enjoyed the process of making a care plan (including what they saw as collaborative goal setting) and were engaged with their plan. They said the care plan helped them to 1) more likely get the care they needed (e.g., physicals, dental, preventive screenings) and 2) stay focused on and motivated towards reaching their health and health care goals. Those less interested in their care plan felt it had little impact in this regard.

**Most recalled signing their plan and mailing it back to the care coordinator.** A few had signed and given it to their care coordinator in person during a home visit, and a few seemed to have given their verbal approval over the phone (they did not remember signing anything).

**In most cases, if participants made any changes to their care plans, they did so during an annual assessment-oriented call with their care coordinator.** Only a very few, who were much more engaged with their care plans than others, made ongoing proactive adjustments to it.

**Most indicated that they had set (or at least talked about) goals during conversations with a care coordinator.** They reported setting a mix of medical and more personal goals – e.g., “lowering my blood pressure” but also “to walk the dog more.”

**About half of those who had care plans said they tracked their progress toward meeting their goals.** Primarily, they monitored their own progress (e.g., by weighing themselves). In some cases, care coordinators and health care providers were also involved.

### **LTSS Discussion**

**LTSS participants also discussed topics that were relevant to the additional services they used. (LTSS participants were queried in Detroit only.) Most received personal care services – especially for light housekeeping and meal preparation.** Overall, they reported high satisfaction with (and appreciation for) the help they received. They reported almost no difficulties in getting the services set up and establishing a relationship with a personal caregiver, whether it was a paid family member or other home health worker. Several said their care coordinator had encouraged their family member to get approved as a caregiver.

**Some LTSS participants had also received HCBS waiver services.** These included modifications and equipment for safety (e.g. shower grab bars, railings on stairways, lift chairs). Participants said that the Area Agency on Aging authorizes these services. There was not extensive discussion of this topic – but all were positive about the work or items they received, and none reported any problems or concerns related to getting them.

### **Behavioral Health Discussion**

**BH participants discussed selected topics related to the BH-specific services they used.** BH participants were queried in Detroit only.

**BH participants reported mixed satisfaction with their BH services.** They appreciated affordable access to therapy and the psychiatric medication that they needed, and several said they were getting valuable help since being enrolled. However, some were lukewarm about the overall quality of mental health care that was available to them and concerned about turnover among participating counselors/therapists.

**All said they called the plan directly to set up behavioral health care – their MI Health Link care coordinator had not been involved.** A few said their care coordinator had provided them with a list of numbers to call for services. Most were not aware of collaboration between their care coordinator and their behavioral health case manager/caseworker (if they had one). However, a few were - they said the two did connect and kept each other apprised of their situation.

### **Impact of MI Health Link on Health, Well-Being, and Quality of Life**

In summary, virtually all participants felt that being enrolled in a MI Health Link plan had positively affected their lives. Most said their quality of life had improved since enrolling, that

they took better care of themselves, and that they were encouraged to do so by the plan and their care coordinators. Relevant participant comments included the following:

- ✚ *“I wouldn’t have any health insurance if it weren’t for the plan. It’s been really, really good.”* (General, Upper Peninsula)
- ✚ *“Now I don’t have the copay, so I’m more apt to do my preventive care, which makes you feel better in the long run.”* (BH, Detroit)
- ✚ *“It totally saved my life. That’s all I know.”* (General, Detroit)

Ultimately, participants were relieved to have access to health care without financial barriers, stress, and anxiety.