kaiser commission on medicaid and the uninsured

MEDICAID FACTS

THE HENRY J. KAISER FAMILY FOUNDATION

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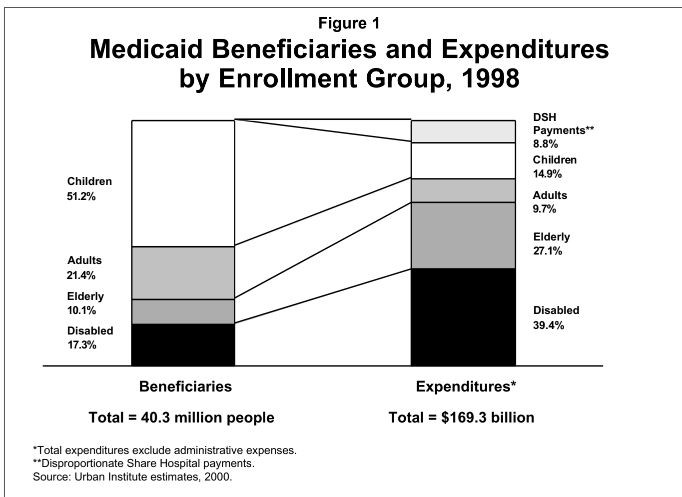
MEDICAID'S DISABLED POPULATION AND MANAGED CARE

In 1998, 1.6 million non-elderly persons with disabilities were enrolled in Medicaid managed care, representing 12% of total Medicaid managed care enrollment. Most of the plans serving this population were initially developed for low-income families and are not targeted specifically to the disabled. Because the health needs of persons with disabilities are often complex and extensive, enrollment in managed care poses significant challenges for assuring access and quality of care.

Medicaid Enrollees with Disabilities

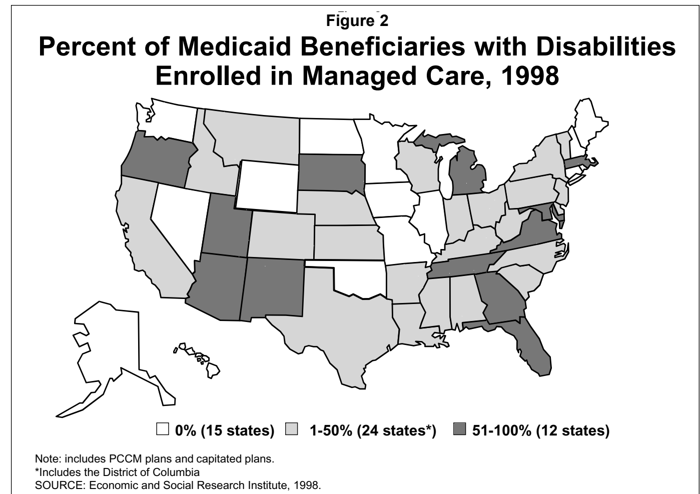
Of the 40 million low-income people Medicaid covers, nearly 7 million beneficiaries qualified in 1998 based on disability, including physical disabilities, mental retardation/ developmental disabilities, and/or mental illness. Typically, persons with disabilities qualify for Medicaid by meeting the requirements of the Supplemental Security Income (SSI) cash assistance program. Additionally, individuals can qualify if their medical expenses enable them to "spend down" to a state's medically needy standard.

Disabled persons in Medicaid account for 17% of all beneficiaries, but nearly 40% of total Medicaid expenditures because of their intensive use of acute and long-term care services (Figure 1). Acute care accounts for 57% of spending on the disabled, while long term care accounts for 43%.

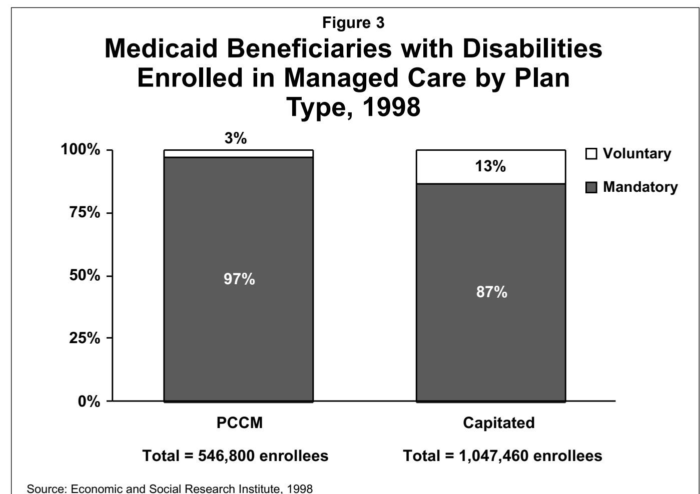


Managed Care Enrollment

About one in four non-elderly persons with disabilities in Medicaid was enrolled in managed care in 1998. Six states enroll over three quarters of their state's disabled Medicaid beneficiaries in managed care (TN, NM, SD, AZ, OR, MD) (Figure 2). Fifteen states do not enroll persons with disabilities in managed care. Minnesota and Washington previously enrolled persons with disabilities into managed care, but have now moved this group back to fee-for-service. Many states do not include people in intermediate care facilities for the mentally retarded, nursing homes, or persons in home and community-based waiver programs in managed care.



The thirty-six states that enroll persons with disabilities use various models of managed care; 16 states use both capitated and primary care case management (PCCM) plans, 14 states only use capitated plans, and 6 states only use PCCM plans. The majority of the disabled population are enrolled in mandatory, capitated plans (Figure 3). Some states operate statewide managed care programs serving all Medicaid beneficiaries, while others target certain counties or population groups, such as disabled children. For example, Michigan has a small voluntary program for children with special health needs, in addition to their mandatory capitated program for disabled and non-disabled Medicaid beneficiaries.



Managed Care Program Features

Four states (Wisconsin, Indiana, Michigan, and Ohio) and the District of Columbia enroll persons with disabilities in arrangements designed exclusively for persons with special health care needs. However, most states (31) enroll Medicaid beneficiaries with disabilities in mainstream managed care programs designed for the general Medicaid population.

These programs may or may not have special features designed to facilitate the enrollment of persons with disabilities (Figure 4). The Medicaid managed care enrollment process often does not identify persons with disabilities; therefore, plans may have difficulty determining those with special health needs. States operate a total of 58 managed care programs for persons with disabilities with varying program features described below.

- ***Enrollment***—Many programs apply the same enrollment features, including brokers, guaranteed eligibility, and lock-ins, used for low-income families. However, 7 programs conduct home visits to enroll persons with special health care needs or have special staff members/volunteers who provide assistance through the enrollment process. Four programs work with the enrollee to select a provider.
- ***Auto Assignment***—When a beneficiary does not choose a plan/provider, most states automatically assign that individual into a plan. Massachusetts does not automatically assign persons with disabilities into capitated plans and Oregon's PCCM option does not automatically assign persons with disabilities.
- ***Case Management***—Out of the 58 programs, only 14 require plans to assign case managers to persons with disabilities.
- ***Health Assessment***—Only about one quarter of the 58 programs require health plans or providers to conduct a health assessment or ask enrollees to complete a health questionnaire. Several programs also conduct such assessments voluntarily.
- ***Access***—Most programs do not have special features to assure access for people with disabilities. Less than half of the programs require a provider to see a newly enrolled disabled beneficiary within a specific time requirement; 26 programs have requirements that range from 30 days after enrollment to 9 months.

Figure 4

Number of Managed Care Programs for Disabled Medicaid Beneficiaries with Selected Features, 1998

Eligibility/ Enrollment	Care Delivery	Rate Setting	Delivery of Behavioral Health Services
Enrollment Broker 34	Time Period for Initial Visit 26	Categorical Eligibility 31	Fee-for-Service 17
Guaranteed Eligibility 15	Case Manager 14	Age, Gender or Area 25	Behavioral Health Org. 16
Lock-in 21	Health Questionnaire 17	Other Factors 11	Managed Care Org. 15

Note: A total of 58 managed care programs enroll disabled Medicaid beneficiaries in 36 states.

Source: Economic and Social Research Institute, 1998.

Quality Assurance

While all of the capitated managed care arrangements include quality assurance components in their contractual arrangements with managed care organizations, they do not always address the unique needs of persons with disabilities. Fifteen programs have quality assurance provisions pertaining to the specific needs of the disabled.

Vermont's *Health Access* program has designated a state "managed care ombudsman" to address issues concerning persons in Medicaid with disabilities. Oregon's quality assurance program requires that all managed care organizations have exceptional needs care coordinators.

Most states are beginning to receive encounter data from the plans, although it is not yet accurate or complete enough to provide useful and comparative information about the types and amounts of services that persons with disabilities are receiving.

Rate Setting

Setting appropriate capitation rates is important to assure that persons with disabilities have access to care and that plans are paid adequately. The cost of serving persons with disabilities is substantial. In 1998, on a per capita basis, Medicaid spent $9,558 on persons with disabilities, compared to $1,558 for non-disabled adults and children. Almost all of the states modify their rates according to categorical status (e.g., SSI, medically needy). State programs also vary rates based on age (23), gender (17), and geographic area (11). Eleven states use additional factors to adjust rates, such as HIV/AIDS (CA, and UT), resource use (CO and OH), diagnostic categories (IN, MA, MD, MI, and WI), and adverse selection (NE and TN).

Benefits

While some of the capitated programs require managed care organizations to provide all Medicaid benefits, many others either create separate programs for certain types of services, or cover them through Medicaid fee-for-service. Such "carve-out" benefits include behavioral health, pharmacy, dental, hospice, long-term care, and chiropractic care. Of the 36 capitated programs, most (31) provide at least some benefits outside of the basic capitation rate paid to the plans. For example, 8 programs cover pharmaceuticals outside of the capitation rate and 5 programs make separate arrangements for dental care.

Currently, persons with disabilities can receive behavioral health services on a fee-for-service basis through their capitated or PCCM arrangement (17 programs); from an outside behavioral health organization, which is paid a capitated fee (16 programs); through their managed care organization (15 programs); or through some other mixed arrangement (10 programs).

Issues and Challenges

As the number of persons with disabilities enrolled in Medicaid managed care grows, and as states continue to confront enrollment, service delivery, payment and quality issues that are vital to the delivery of appropriate care, it will be extremely important to assess how well these programs serve this vulnerable population. While managed care is attractive because of its potential to improve the delivery and coordination of services, the inherent financial incentives to provide fewer services under capitated rates may cause people with chronic conditions to be underserved. Improved encounter data, coupled with targeted external quality assurance studies, could yield valuable information about how persons with disabilities are cared for by Medicaid managed care arrangements.

Drawn from *Medicaid Managed Care for Persons with Disabilities: State Profiles* by Marsha Regenstein and Christy Schroer, the Economic and Social Research Institute, December, 1998. Prepared for the Kaiser Commission on Medicaid and the Uninsured.

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