

# medicaid and the uninsured

February 2012

## People with Disabilities and Medicaid Managed Care: Key Issues to Consider

### Executive Summary

Individuals with disabilities are, by definition, a Medicaid population with special needs. Precisely because of their high needs and costs, Medicaid beneficiaries with disabilities are increasingly a focus of state efforts to improve care and manage Medicaid spending more effectively. In most states now, some children and/or adults with disabilities are subject to mandatory enrollment in managed care arrangements for at least some of their care, and more states are moving in this direction. Further, beginning in 2014, the Affordable Care Act will expand Medicaid to reach millions of low-income uninsured Americans, including many with disabilities, and states are widely expected to rely on managed care organizations to serve the newly eligible, mostly adult, population.

While managed care offers tools to improve care coordination and quality, identification of the conditions and structures essential to promote these aims, and of the problems that may result if they are absent, can help guide the design of sound managed care programs for all Medicaid beneficiaries, and particularly for beneficiaries with disabilities, for whom both the potential risks and gains may be greatest. To that end, this brief examines central issues in Medicaid managed acute care through the lens of disability. A [companion paper](#) examines issues in Medicaid managed long-term care, and a separate [brief](#) provides a current overview of Medicaid managed care more broadly.

#### Key considerations concerning payment

- **Establishing capitation rates for persons with disabilities poses special challenges.** Capitation rates must be sufficient to enable managed care organizations (MCOs) to recruit the provider networks necessary to care for enrollees with diverse disabilities, and they must take into account the cost of specialized services and the higher cost of managing care for complex patients. Evidence of significant unmet need among Medicaid beneficiaries with disabilities in fee-for-service (FFS) suggests that FFS utilization may not provide a sound basis for setting capitation rates. Risk-adjustment systems based on diagnostic information, prior FFS claims, or MCO encounter data can improve the appropriateness of capitation rates, mitigate jeopardy to the quality of care, and help ensure that MCOs with higher-need enrollees are not penalized, but getting adequate plan data to support these systems remains a key challenge.
- **Risk-based managed care for persons with disabilities is not likely to generate short-term savings.** Medicaid FFS payment rates, on which capitation rates may be based, are already so low in many states that there is no “room” to extract cost savings by reducing price, leaving utilization as the remaining source of potential savings. However, unmet need among beneficiaries with disabilities, high initial utilization due to pent-up demand and improved care coordination, and up-front administrative costs make near-term Medicaid savings from managed care for this population unlikely. The potential for savings lies in more appropriate patterns of care over time, especially reduced hospital use, which may result from better prescription drug management and more advanced clinical management and care coordination for people with disabilities.

#### Key considerations concerning provider networks and delivery systems

- **MCOs will need broader provider networks.** People with disabilities require both acute and long-term care from a wide array of specialists and specialized facilities that may not be represented adequately or at all in Medicaid MCOs’ existing networks. Access problems now encountered by some comparatively healthy beneficiaries can be expected to be greater for those with more extensive and diverse needs unless plans are able to recruit appropriate networks of providers.

- **Physically accessible facilities and other accommodations are needed.** MCOs may need to acquire more expertise to identify and assess chronic physical and mental health needs, as well as provide special outreach and accommodations to ensure meaningful access and adequate care for Medicaid enrollees with disabilities. For example, effective communication, such as through sign language interpreters, and culturally competent clinicians and staff, are needed, as are physically accessible services and equipment. Dedicated outreach and follow-up may be critical to assist individuals who are severely mentally ill, in particular, with getting to appointments or adhering to treatment.
- **Improved integration of behavioral and physical health care is a priority.** As over half of Medicaid beneficiaries with disabilities have a diagnosed mental illness, team-based care and other models that facilitate integration of behavioral and physical health care are needed. States can promote such models by requiring information-sharing among providers and holding provider teams collectively accountable for performance. Mental health, pharmacy, and other “carve-outs” and subcontracts raise concerns about patient navigation and fragmentation of care. Contract provisions that facilitate or require data-sharing and coordination across entities are essential, especially for those with mental health comorbidities, and because of the large impact of mental illness on hospitalization rates and overall Medicaid costs.
- **Coordination between acute and long-term services and supports is important for many with disabilities.** Managed long-term care programs may provide states an avenue for creating more cost-effective arrangements and integrating acute and long-term services and supports (LTSS), but experience and evidence are still limited. MCOs’ ability to coordinate and manage LTSS is affected by the extent to which the program covers institutional services, medical care, and behavioral health services, in addition to community-based LTSS. Involving community-based organizations in program design may help ensure an adequate supply of LTSS, as these organizations often have strong ties to LTSS referrals or services.

#### Key considerations regarding beneficiary protection and oversight of managed care

- **Beneficiary engagement is crucial, and outreach and assistance are vital to ensure that beneficiaries with disabilities understand managed care.** Early and ongoing beneficiary and other stakeholder input is necessary to identify the concerns and needs of people with disabilities and design programs that are responsive and adequate. Mechanisms for public engagement include public meetings, focus groups, and planning and oversight committees. A priority for states enrolling people with disabilities in managed care must be ensuring that enrollees understand how managed care operates. Lower health literacy in this population suggests needs for focused outreach and education regarding how to use services, restrictions on provider choice, grievance and appeals rights, and other aspects of managed care. “Choice counselors” could be helpful to beneficiaries in evaluating their plan options.
- **Voluntary enrollment and provisions to smooth transitions from FFS could mitigate disruptions in patient-provider relationships and treatment.** Mandatory enrollment in managed care can jeopardize continuity of care if it disrupts longstanding treatment relationships and processes. States can exempt people with disabilities from managed care or adopt a policy of voluntary rather than mandatory enrollment. States can also promote managed care without mandating it by automatically enrolling people initially but permitting them to opt out. Other approaches to maximizing continuity for those in active treatment, such as longer enrollment periods, or smart use of utilization data to match enrollees with MCOs that include their providers or have expertise relevant to their conditions, could help to ease transitions from FFS to managed care.
- **Encounter data are essential to assess access and quality and to set actuarially sound rates.** While states are required to collect and report encounter data from MCOs, CMS has not enforced this requirement. As a result, no national database exists to support analysis of important Medicaid managed care measures. Current federal reporting systems capture only the payments states make to MCOs on behalf of Medicaid enrollees; they lack individual-level utilization data needed to evaluate access and care and to support oversight. As states enroll more medically complex beneficiaries in managed care, the need for detailed encounter data to assess access, set actuarially sound rates, and hold plans accountable is increasingly pressing.

- **Specialized measures of access and quality and robust monitoring are needed.** Widely used quality measure sets (e.g., HEDIS and CAHPS) do not take into account or include targeted measures that reflect the special needs of people with disabilities. Nor have quality measures for LTSS been developed, a problematic gap in the context of efforts to integrate management of LTSS and acute health care. To address these shortcomings, some states and plans conduct targeted monitoring of selected measures of access, utilization, or care that are of key importance for patients with a specified condition or disability. Examples include monitoring of cervical cancer screening for women who are HIV-positive, dental visits for people with developmental disabilities, and rates of hospitalization for pressure sores and falls or fractures among persons with severe physical disabilities.
- **Careful contracting and state oversight are essential.** Contracts are the principal mechanism states have for ensuring that MCOs are accountable for delivering adequate and high-quality care to their Medicaid enrollees; therefore, specificity in contracts is crucial. In addition, “secret shopper” surveys to audit provider availability, strategic analysis of encounter data to monitor and assess access and guide rate-setting, and aggressive use of performance measurement to drive quality, are among the state oversight activities needed to ensure effective and efficient program administration, including meaningful beneficiary protection. State staff capacity and resources to conduct these operations and enforce standards are fundamental.
- **States can strengthen protections for beneficiaries enrolled in MCOs.** Medicaid MCO enrollees retain their due process rights regarding the entitlement to Medicaid benefits, and federal law also provides additional protections for beneficiaries in MCOs. States can enhance protections for beneficiaries, for example, by establishing a state Medicaid ombudsman program to mediate disputes or advocate on behalf of beneficiaries, or programs in which independent, external reviewers evaluate the merits of grievances and appeals. The effectiveness of such initiatives will depend on the resources states devote to them, outreach to increase beneficiaries’ awareness of their rights and how to exercise them, and beneficiaries’ access to counsel.

## Looking Ahead

As Medicaid policy officials seek both to contend with ongoing budget pressures and to adopt delivery and payment system reforms designed to improve care and gain more from their Medicaid spending, the current trend toward enrolling Medicaid beneficiaries with disabilities in managed care seems likely to continue. As more states weigh moving in this direction, and as millions of additional low-income adults, including many with disabilities, obtain Medicaid under the ACA beginning in 2014, a set of special concerns for this high-need population – related to outreach and education, system navigation, access to services, and beneficiary protection and oversight – warrants careful consideration. The capacity of states to invest sufficient resources in these efforts is also key.

Managed care offers potential to increase access and improve the coordination of care, particularly for those with the most complex needs. At the same time, it has the potential to disrupt access and care and to compromise the well-being of beneficiaries if they are unable to navigate the system or health plans are not equipped to meet their needs. The actual performance of managed care in serving Medicaid enrollees with disabilities will depend on the specifics of states’ managed care contracts, and on many program design and oversight issues. Therefore, states’ decisions about how their managed care delivery and payment systems are structured will matter greatly going forward, and the rigor and enforcement of their contracts with MCOs will strongly influence the extent to which state goals for improving access and care and reducing costs for Medicaid beneficiaries with disabilities translate into plan accountability for these outcomes. Close study and ongoing assessment of those managed care programs that serve Medicaid beneficiaries with disabilities can help to identify the attributes of successful models, providing valuable guidance as states move ahead.

# People with Disabilities and Medicaid Managed Care: Key Issues to Consider

## INTRODUCTION

Medicaid, our nation’s public health coverage program for individuals and families with low incomes, covers about 60 million people today – approximately 1 in 5 Americans. Among Medicaid’s diverse beneficiaries are 8.8 million working-age adults and children with many types of physical, mental, and cognitive disabilities and chronic conditions. These individuals rely on the Medicaid program for a broad spectrum of services, from basic medical care to behavioral health care and long-term services and supports that make employment and independent living possible.

Because of their high health care needs, utilization, and costs, individuals with disabilities are a Medicaid population of special concern. They have the most at stake in terms of health care access and the organization and quality of care. Also, their needs and costs are important drivers of state and federal Medicaid spending and are increasingly an important focus of efforts to manage Medicaid spending more effectively. In that light, and in light of the Medicaid expansion under the Affordable Care Act, which will add millions of low-income adults to the program, including many with disabilities, the growing trend among states toward enrolling Medicaid beneficiaries with disabilities in managed care arrangements for their acute care needs warrants close examination. In a recent [50-state survey](#) of Medicaid managed care, conducted by the Kaiser Family Foundation’s Kaiser Commission on Medicaid and the Uninsured, a majority of states reported that, for at least one managed care program or geographic area, they mandate managed care enrollment for some children and/or adults with disabilities.<sup>1</sup> While beyond the scope of this brief, wider use of managed care for beneficiaries who are dually eligible for Medicaid and Medicare, and growth in managed long-term care programs, are important related developments.

While risk-based managed care offers tools to improve care coordination and quality, identification of the conditions and structures that are necessary to promote these aims, and of the problems that may arise when they are absent, can help guide the design of sound managed care programs for all Medicaid beneficiaries, and particularly for beneficiaries with disabilities, for whom both the potential risks and gains may be greatest. To that end, this paper examines central issues in risk-based managed acute care in Medicaid through the lens of disability. A [companion paper](#) examines issues in Medicaid managed long-term care, and a separate [brief](#) provides a current overview of Medicaid managed care more broadly.<sup>2,3</sup>

## UNDERSTANDING THE CONTEXT

There is no single profile of Medicaid beneficiaries with disabilities. On the contrary, this term describes low-income individuals, both children and working-age adults, with a wide range of physical disabilities, mental illnesses, intellectual and other developmental disabilities, spinal cord and traumatic brain injuries, and chronic, disabling diseases.<sup>4</sup>

Reflecting the diversity of their ages, disabilities, and conditions, Medicaid beneficiaries with disabilities have needs for many different kinds of care, including the preventive and primary medical care that everyone needs, as well as more specialized and intensive medical care, durable medical equipment, long-term care provided in nursing homes and intermediate care facilities (primarily ICFs/MR\*), and home and community-based long-term services and supports. Accordingly, Medicaid spending for beneficiaries with disabilities is distributed across a broad array of services and settings (Figure 1).

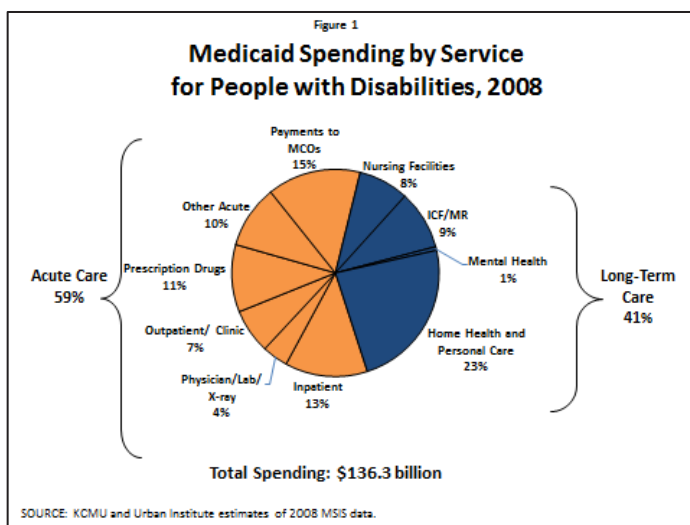
### Disability among Medicaid beneficiaries

Medicaid beneficiaries with disabilities, who include both children and adults, are a heterogeneous population, with a wide range of physical and mental disabilities and disabling conditions, including but not limited to:

- blindness;
- spinal cord and traumatic brain injury;
- severe mental or emotional conditions, including mental illness (e.g., depression, bipolar disorder) and intellectual disabilities (e.g., ADHD);
- Parkinson’s disease;
- cerebral palsy;
- cystic fibrosis;
- epilepsy;
- multiple sclerosis;
- Down Syndrome;
- Alzheimer’s disease;
- autism;
- spina bifida;
- Muscular dystrophy; and
- HIV/AIDS

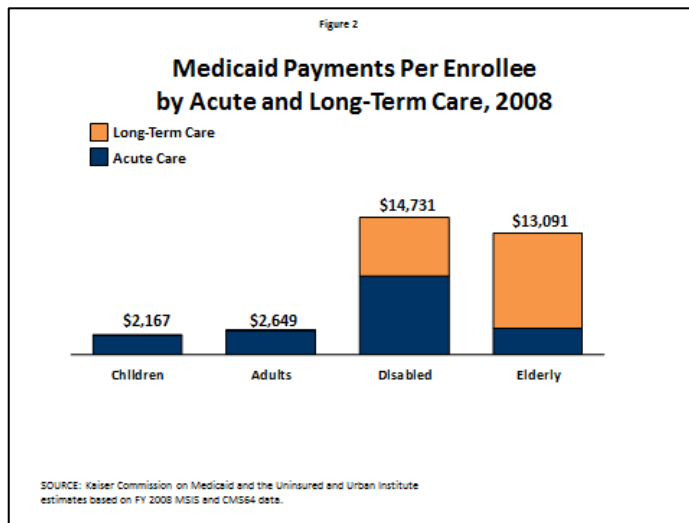
As might be expected in light of their more complex and extensive needs for care, Medicaid beneficiaries with disabilities have the highest Medicaid spending per capita of any eligibility group, for both acute and long-term care services (Figure 2). Because of their greater needs and the high costs of their care, the 15 percent of Medicaid beneficiaries with disabilities account for a disproportionate share – 42 percent – of total Medicaid spending for services.

While most Medicaid beneficiaries with disabilities receive their care in the fee-for-service (FFS) environment, about 16 percent of their spending reflects Medicaid managed care payments made on their behalf, primarily to capitated managed care organizations (MCOs). Enrollment of Medicaid beneficiaries in risk-based managed care programs has been growing steadily since the 1980s. As of October 2010,



\* “ICF/MR,” the term used in federal Medicaid law and regulations, refers to an intermediate care facility for the mentally retarded. The preferred terminology today is “intermediate care facility for individuals with intellectual disabilities” or ICF/ID.

almost two-thirds of all Medicaid beneficiaries were enrolled either in an MCO or in a primary care case management (PCCM) program, the other major model of Medicaid managed care.<sup>5</sup> However, the vast majority of Medicaid beneficiaries enrolled in managed care (often, on a mandatory basis) are pregnant women, children, and parents and other caretaker adults without disabilities. States have been far less likely to extend managed care to Medicaid beneficiaries with disabilities, because of their more involved needs, concerns about provider network adequacy, and limited health plan experience serving and bearing risk for this population; also, enrollment in managed care has usually been on a voluntary rather than a mandatory basis for these individuals. Thus, managed care has so far remained a relatively small phenomenon among Medicaid beneficiaries with disabilities.



Lately, however, a growing number of states have been turning to risk-based managed care, including mandatory enrollment in MCOs, for Medicaid beneficiaries with disabilities. In the survey mentioned above, 26 states reported mandating managed care for at least some children who receive SSI, and well over half mandate managed care for at least some children with special health care needs (32 states) and adults with disabilities (33 states). Further, a recent survey of state budget actions in Medicaid in 2011 and 2012 shows that state movement in this direction is continuing. Two principal factors are motivating increased state interest in risk-based managed care for Medicaid beneficiaries with disabilities. First, under severe, ongoing budget pressures, states are seeking ways to reduce, and to increase the predictability of, Medicaid spending. Second, there are widening efforts among state Medicaid programs to improve the delivery and quality of care, particularly for beneficiaries with complex and costly needs whose care is fragmented and uncoordinated.

Medicaid's typically very low FFS provider payment rates relative to Medicare and private payers may make it difficult for states to extract savings from managed care from lower unit pricing. As states respond to ongoing budget pressures by reducing provider payment rates further, the remaining source of potential savings is reduced utilization, either from improved patterns of care, which are likely to take time to materialize, or by means such as more restrictive drug formularies, service limits, and tight provider networks. In light of evidence of large unmet needs for specialized care among individuals with disabilities, such budget-driven measures aimed at reducing utilization raise concerns and could pose significant risks to access to care for this underserved population.

Research examining the impact of Medicaid risk-based managed care on access, quality of care, costs, and other outcomes of interest has produced mixed evidence, and it suggests that the effects of managed care depend on many factors, including important details of how managed care arrangements are structured, financed, and implemented. In addition, the findings from studies of Medicaid managed care overall may not be generalizable to Medicaid beneficiaries with disabilities, whose health profiles, health care needs, and costs differ from those of the healthier Medicaid beneficiaries more typically

enrolled in managed care. (A summary of key research on people with disabilities and Medicaid managed care is included as an Appendix.)

Given the limited experience and evidence available to guide policy in this area, it is important, as states take steps to expand managed care, to identify special issues and concerns associated with risk-based managed care for people with disabilities. This brief discusses key considerations in three major domains – payment, provider networks and delivery systems, and patient protections and program oversight. It also discusses enhanced Primary Care Case Management (PCCM) programs as an alternative managed care model that offers states levers for improving care outside a risk-based context.

## KEY CONSIDERATIONS CONCERNING PAYMENT

In risk-based Medicaid managed care, states contract with MCOs to provide some or all Medicaid-covered services for Medicaid enrollees, paying the plans a prospectively set, per-member-per-month (PMPM) or “capitation” rate for each beneficiary. The MCOs are at financial risk for delivering all medically necessary services defined under the contract. Federal law (section 1903(m)(2)(A)(iii) of the Social Security Act) and regulations (42 CFR 438.6(c)) require that states pay MCOs capitation rates that are “actuarially sound.” Historically, states adopting managed care have tended to use FFS payment rates and utilization as a starting point for setting capitation rates, relying more heavily on encounter data and negotiation to set rates as their managed care programs mature.

Ideally, states set capitation rates in a manner that adequately compensates MCOs for providing needed care, taking into account the profile and utilization experience of their Medicaid enrollees, while also giving plans a financial incentive to manage that care effectively and efficiently by improving access and coordination of care, and reducing fragmentation and duplication of services. However, there is an inherent risk of underservice in prepaid systems. This risk, which leaves individuals with the greatest needs for services potentially most exposed, underscores the importance of sound rates.

### Setting appropriate capitation rates

- ***Establishing capitation rates for people with disabilities poses special challenges.*** Setting capitation rates for Medicaid beneficiaries with disabilities is complicated on several accounts. The population includes individuals with a wide range of disabling conditions and diseases who require diverse, extensive, and specialized services and supports. Capitation rates for persons with disabilities must be sufficient to enable MCOs to recruit the types of providers to their networks that are necessary to care for this population, and take into account the costs of specialized services, supports, and equipment, as well as higher care management and other costs associated with the care of complex patients. Risk-adjustment or health-based payment systems that use diagnostic information, prior FFS claims, or MCO encounter data have been developed to improve the appropriateness of rates paid to plans based on the profile of their enrollees, to mitigate risk-selection and jeopardy to the quality of care and to ensure that plans with higher-need enrollees are not penalized. However, getting adequate and consistent data from health plans as needed to support these systems remains a key implementation challenge.<sup>6</sup>

Also, evidence of significant unmet need among beneficiaries with disabilities in the FFS system suggests that their FFS utilization experience may not provide a sound basis for setting adequate capitation rates. Further, to secure provider participation, MCOs may have to pay providers rates

that exceed Medicaid’s very low FFS reimbursement levels, making cost savings relative to FFS difficult if not impossible to achieve through pressure on the price component of capitation rates.<sup>7</sup>

- ***If capitation payment rates are adequate, they could provide MCOs with flexibility to allocate payments among a variety of services to better accommodate beneficiaries with disabilities.*** For example, MCOs could use capitation dollars to provide member education and outreach materials designed specifically for this population, provider directories with physical accessibility ratings, and/or improved care coordination through case managers. Also, because they are not bound by the state’s FFS provider payment rates, plans could pay providers more for serving beneficiaries with disabilities and offer bonuses for chronic disease care to encourage specialist participation in plan networks and ultimately increase beneficiary access to providers. State contracts with plans could also drive quality and accountability by specifying benchmarks for performance and structuring payment to reward achievement and penalize underperformance.
- ***Minimum medical loss ratios (MLR) ensure that Medicaid dollars finance services to beneficiaries.*** A medical loss ratio is the share of premium dollars an insurer or health plan spends on health services, as opposed to administration, marketing, executive salaries, and profits. Requiring minimum MLRs for Medicaid MCOs is a means of guaranteeing that the public dollars that states spend on capitation payments to MCOs are used largely to provide services to Medicaid enrollees. According to Kaiser’s 50-state survey of Medicaid managed care, not quite a third of the states with risk-based managed care report having minimum MLR requirements, including one state that has a higher minimum MLR for plans serving its aged and disabled populations.\* Recently, CMS required that Medicaid plans meet a minimum MLR standard of 85% as a condition of extending Florida’s 1115 demonstration waiver, which mandates managed care for most Medicaid beneficiaries in five counties. This was the first such action by CMS and may signal that a Medicaid MLR standard could emerge as a federal requirement as states seek to move more Medicaid beneficiaries, including those with complex needs, into managed care on a mandatory basis. However, CMS did not stipulate a minimum MLR in its recent approval of California’s “Bridge to Reform” 1115 waiver, which mandates managed care for non-dually eligible seniors and people with disabilities.
- ***Risk-sharing arrangements, which limit plan financial risk, may help to protect beneficiaries as well, particularly while states and plans gain more experience serving individuals with disabilities in capitated managed care.*** Half the states that contract with risk-based MCOs currently have risk-sharing arrangements with health plans, mostly to help encourage MCO participation by limiting their downside financial exposure. Especially until more experience with managed care for Medicaid beneficiaries with disabilities accumulates and more refined risk-adjustment and predictive modeling strategies evolve, mechanisms like overall or condition-specific risk corridors or reinsurance that shield MCOs from financial risk beyond a certain threshold may promote stability and continuity in plan participation in Medicaid and also serve to protect Medicaid enrollees against the risk of underservice.

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\* These states are Arizona (84%), DC (85%), Hawaii (91.5%; 93% for plans serving aged and disabled populations), Illinois (80%), Indiana (85%), Maryland (85%), New Jersey (80%), New Mexico (85%), Ohio (85%), Virginia (92%), and Washington (80%). Also, California, Michigan, and Minnesota indicated that they plan to establish an MLR requirement in the future.



## Savings from managed care are uncertain

- **Short-term savings from managed care for persons with disabilities are likely to be elusive.** Although risk-based managed care offers states increased budget predictability, managed care for persons with disabilities has not produced short-term Medicaid savings for states. Medicaid FFS payment rates, on which capitation rates may be based, are already so low in many states that there is effectively no “room” to extract cost savings by reducing price.<sup>8</sup> That leaves utilization as the remaining source of potential savings. However, there is no evidence of over-utilization by beneficiaries with disabilities. On the contrary, large unmet needs for specialized care, high initial utilization due to pent-up demand and improved care coordination, and up-front administrative costs may help to explain why near-term savings, at least, have not materialized.<sup>9 10</sup> In addition, effective care coordination for disabled beneficiaries requires a more intense and likely more expensive, multidisciplinary, team-based approach that spans health and social services, organizes and disseminates case information across providers, and includes face-to-face case management with active and regular beneficiary outreach efforts.<sup>11 12</sup>
- **Sound efforts to reduce Medicaid spending associated with individuals with disabilities will focus on improving access and care management for these beneficiaries.** Research examining the experience of four states that adopted managed care for adult Medicaid beneficiaries with disabilities suggests that managed care initiatives for this population that are driven by short-term budget imperatives are ill-advised. The potential for savings, the study concludes, lies in more appropriate patterns of care over time, especially reduced hospital utilization, that may result from better management of prescription drug use and more advanced clinical management and care coordination for people with disabilities.<sup>13</sup>

## KEY CONSIDERATIONS CONCERNING PROVIDER NETWORKS AND DELIVERY SYSTEMS

Considering the often intensive needs for care among persons with disabilities and the diversity of their conditions and disabilities, it is important for state Medicaid programs and capitated health plans to ensure timely access to the comprehensive range of services these beneficiaries may require, including preventive and acute medical care, but also pharmacy, behavioral, and long-term services and supports. The number, mix, and geographic location of providers available to serve this population need to be sufficient to provide robust access to care. In addition, because many individuals with disabilities receive a broad spectrum of health and supportive services, coordination among providers is critical to providing high-quality care and improving outcomes for this population.

### Broader networks and improved accessibility

- **To serve Medicaid beneficiaries with disabilities adequately, many MCOs will need broader provider networks.** The disabled population, which includes people with developmental, mental health, and physical conditions, requires both acute and long-term care from a wide array of specialists and specialized facilities that may not be represented adequately or at all in Medicaid MCOs’ existing provider networks. In the recent Kaiser survey of Medicaid managed care, 25 states reported that Medicaid beneficiaries in MCOs sometimes experience access problems. States cited gaps in access to many different types of services, including dental care, pediatric specialists, psychiatrists and other behavioral health providers, and other specialists (e.g., dermatologists, ear-nose-throat specialists, orthopedists, and other surgeons, neurologists, cancer and diabetes specialists); provider shortages and other market factors were often given as the cause.<sup>14</sup> These

access problems, encountered by the comparatively healthier Medicaid beneficiaries now enrolled in MCOs, can be expected to be greater for beneficiaries with more extensive and diverse needs for care. Evidence from a recent national study indicates that working-age disabled Medicaid beneficiaries enrolled in mandatory managed care were significantly more likely than those in FFS to report a problem accessing a specialist.<sup>15</sup> Provider networks geared to meet the exceptional health and other needs of people with disabilities are vital to the design of managed care programs able to serve this population adequately. In approving California’s Bridge to Reform 1115 demonstration waiver, CMS included in its “standard terms and conditions” readiness requirements related to network adequacy and access for plans wishing to enroll seniors and people with disabilities.<sup>16</sup>

- ***Reasonable travel and wait times for appointments are key considerations in developing and evaluating provider networks for beneficiaries with disabilities.*** State contracts with MCOs often specify maximum travel times or distances to providers, and maximum wait times for appointments, as structural measures of access. Plans may face difficulty meeting these standards for the wider network of providers needed to serve Medicaid beneficiaries with disabilities, particularly given physician shortages in some specialties and in rural areas. Further, the time and distance standards used to ensure access, even if they are sufficient for most enrollees, may need to be modified for individuals with disabilities, who have more frequent and ongoing needs for health services. Again, CMS requirements for California’s Bridge to Reform waiver offer an illustration of the types of standards that can be applied to states and MCOs to ensure adequate and timely access to needed care.<sup>17</sup>
- ***Physical accessibility of health care facilities and an array of other accommodations are needed to ensure meaningful and adequate access for persons with disabilities.*** To serve people with disabilities adequately, health plans must ensure effective communication, such as through the provision of sign language interpreters, and make services physically accessible, for example, by providing for height-adjustable exam tables and diagnostic or radiologic equipment.<sup>18</sup> Recruitment by plans of providers and practices committed to serving persons with cognitive as well as physical and mental health limitations, and provision of cultural competency training for plan clinicians and staff to increase awareness and sensitivity to the special needs of people with disabilities, are part and parcel of strategies to establish care delivery systems capable of serving this population effectively.<sup>19</sup>

### **Integrating behavioral health care**

- ***Improved integration of behavioral and physical health services in managed care programs is a priority concern, as more than half of Medicaid beneficiaries with disabilities have a diagnosed mental illness.*** Many states now “carve out” mental health services, pharmacy, and certain other services from managed care and, even in states that include these services in their managed care contracts, MCOs may deliver this care through subcontractors. While carve-outs can increase beneficiaries’ access to services that MCOs have difficulty procuring or providing, at the same time, divided delivery systems can lead to confusion about which entity is responsible for different types of care, and beneficiaries may find navigating more than one system challenging. Given high rates of physical and mental health comorbidities among people with disabilities, navigation problems as well as fragmentation of care pose significant concerns. If states choose to carve out services from managed care contracts, or MCOs subcontract for some types of care, contract provisions that facilitate data-sharing, care coordination, and disease management across entities are essential.

These provisions are particularly important in regard to behavioral health carve-outs, to support integrated care for enrollees with mental health comorbidities, and also because of the large impact of mental illness on hospitalization rates and overall costs for state Medicaid programs.

- ***Beneficiaries with chronic conditions, particularly those with severe mental illness, may face special challenges in navigating managed care.*** Medicaid beneficiaries with ongoing needs for care or management of their conditions may require extra help, such as special outreach or follow-up, to ensure continuity in their care. In particular, active, dedicated outreach and follow-up by community-based providers may play a critical role in assisting individuals who are severely mentally ill with getting to appointments or following through with treatment. MCOs that have historically served a generally healthier population more accustomed to managed care may need to acquire more expertise to identify and assess chronic physical and mental health needs, as well as provide the outreach, care management activities, and other special supports necessary to ensure appropriate access and care for Medicaid beneficiaries with disabilities.
- ***Co-location of mental health and primary care providers can facilitate integration of their services.*** Through team-based interaction and, when possible, integrated administration and finances, co-located providers can create a single medical record and integrated treatment plan for each patient. This model of integrated care can result in earlier identification of conditions and greater acceptance of referrals; coordinated care plans can also prevent duplication of services and reduce the risk of adverse events.<sup>20</sup> Research has shown evidence of improved outcomes for patients who received co-located substance abuse treatment and primary care, and improved diagnosis and treatment as a result of behavioral health clinicians actively educating and coaching primary care providers.<sup>21 22</sup>

### Meeting coordination challenges

- ***Delivery systems, capitated or not, that rely on multi-disciplinary care teams that include primary care providers, behavioral health specialists, community health workers, and support specialists, can enhance the coordination of care for persons with disabilities.*** States can promote these models by requiring information-sharing among providers and aligning their financial incentives by establishing performance benchmarks for provider teams that all team members can influence and be jointly rewarded for meeting.<sup>23</sup>
- ***Coordination between acute care and long-term services and supports is an important issue for many in the population with disabilities.*** Managed long-term care programs may provide an avenue for states to create more cost-effective arrangements that integrate the delivery and financing of acute and long-term services and supports (LTSS), but experience with and evidence about such programs in Medicaid is still limited. MCOs' ability to coordinate and manage LTSS is affected by the extent to which the program covers institutional services, medical care, and behavioral health services, in addition to community-based LTSS. Also, involving community-based organizations in the design of these programs may be key to ensuring an adequate supply of LTSS, as these organizations often have strong ties with consumers for whom they have provided LTSS referrals or services. Research indicates that managed LTSS programs reduce the use of institutional services and increase access to home and community-based services, but there is little definitive evidence yet about whether the model saves money or how it affects outcomes for beneficiaries.<sup>24</sup>

- ***The new Medicaid “health home” option under the Affordable Care Act provides a new funding opportunity for states to improve care for people with complex and chronic medical needs.*** The ACA established a new state plan option, known as “health homes,” specifically targeted to individuals with chronic conditions and designed to be a person-centered system of comprehensive and highly coordinated care, including linkages to services and supports in the community. The law provides a 90% federal match for health home services for the first eight fiscal quarters a state’s program is in effect, giving states a strong incentive to adopt the option. Health home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care from inpatient to other settings, individual and family support, and referral to community and social support services. States can choose from three models of health home providers, and also determine how to pay them; health homes can be integrated into managed care arrangements; they are also compatible with FFS. So far, Missouri, New York, and Rhode Island have both obtained CMS approval for their health home initiatives, and about half the states have health home state plan amendments under CMS review or in the planning, or have received approval for federal funding requests to develop them.

## **KEY CONSIDERATIONS REGARDING BENEFICIARY PROTECTIONS AND OVERSIGHT OF MANAGED CARE**

While the federal regulatory framework governing state Medicaid managed care programs is extensive, addressing virtually every aspect of managed care, from outreach and marketing to the soundness of capitation rates, and from network adequacy requirements to enrollee appeal rights, the effectiveness of this framework depends on the specificity and rigor of state contracts with MCOs and on strong federal and state oversight. Mechanisms to support informed choice, and performance standards and procedures designed to protect all Medicaid managed care enrollees, must be sufficiently robust to protect those with the greatest needs, ensuring that beneficiaries with disabilities understand their options and that health plans are accountable for providing them with appropriate and high-quality care in a timely manner. Beneficiary protections encompass outreach, engagement, and information about managed care at the “front end,” as well as clearly defined beneficiary rights and avenues for recourse when enrollees face barriers to needed services.

### **Beneficiary engagement and informed choice**

- ***Stakeholder and beneficiary engagement are crucial.*** Substantial stakeholder input, especially from beneficiaries, through all stages of program development and assessment is necessary to fully identify the concerns and needs of people with disabilities and to design programs that are responsive and adequate, ideally improving the quality of care these individuals receive. State Medicaid programs can engage stakeholders through such vehicles as public meetings, focus groups, and planning, advisory, and oversight committees that include stakeholders among their participants.<sup>25</sup>
- ***Adequate outreach, information, and assistance are vital to ensure that beneficiaries with disabilities understand managed care.*** Managed care, particularly capitated managed care, is unfamiliar to many Medicaid beneficiaries with disabilities, who have largely remained in FFS even as states have expanded managed care widely for low-income children and families. A priority for states enrolling persons with disabilities in managed care must be ensuring that these individuals are well-informed about how managed care operates. Persons with disabilities have higher rates of poor health status and lower rates of formal education, both factors associated with poorer health

literacy.<sup>26</sup> Thus, special outreach, education, and assistance efforts are needed to ensure that these beneficiaries receive clear and accurate explanations regarding how to use services, restrictions on provider choice, pre-authorization requirements, grievance and appeals rights, and other aspects of enrollment in managed care.

- ***Several modes of communication may be necessary to inform beneficiaries and engage them in choosing a plan and managing their care.*** Communication modes could include written materials, audiotapes, videos, hotlines, and the Internet. States and MCOs could also develop strategies that include Medicaid providers and/or organizations that deliver social services, such as housing and employment, to publicize and increase awareness of special assistance for people with disabilities. Input from beneficiaries and stakeholders, solicited through focus or advisory groups and public meetings, can help officials determine the most effective ways to convey important information.
- ***“Choice counselors” may be needed to help beneficiaries evaluate their health plan options.*** It is important that those providing assistance to beneficiaries in choosing a plan have substantial knowledge of the particular services and supports their clients need, and of the strengths and limitations of different managed care plans relative to those needs. Up-to-date provider directories with accurate information about providers with open panels are also essential to assist beneficiaries in plan and PCP selection. If states contract for choice counseling services, key contract elements include defined staffing requirements and resources, counseling protocols, and broker training and neutrality regarding available plans. Subject to appropriate privacy protections, enrollment counseling could present a valuable opportunity to collect information that the state or contracted social service agencies could share with MCOs or primary care case managers for purposes of identifying members with special needs, linking care systems at the point of enrollment, and facilitating care coordination.

#### **Managing transitions and helping patients navigate**

- ***Voluntary enrollment or, in a mandatory enrollment context, strategies to smooth transitions for beneficiaries currently in FFS, could mitigate disruptions in established patient-provider relationships and ongoing treatment.*** Continuity of care, a leading concern especially for beneficiaries with chronic and disabling conditions, can be compromised if mandatory enrollment in managed care disrupts longstanding relationships with providers (often, specialists) who have cared for disabled Medicaid beneficiaries on a FFS basis. States can always exempt these beneficiaries from managed care altogether, or, to preserve continuity with providers, adopt a policy of voluntary rather than mandatory enrollment in managed care for persons with disabilities. Alternatively, a state could use an “all-in, opt-out” approach, automatically enrolling beneficiaries but permitting them to opt out. As an illustration, in its capitated financial alignment model for dual eligibles, CMS suggested an opt-out available on a month-to-month basis and also emphasized that passive enrollment must be contingent on the state and CMS establishing appropriate beneficiary protections and mechanisms for providing information to beneficiaries regarding their enrollment options.<sup>27</sup> Other provisions geared toward maximizing continuity of care for beneficiaries in active treatment, such as default assignment algorithms that use utilization data to match enrollees with plans that include their providers and/or have expertise related to their conditions, or longer enrollment periods, could help to ease transitions from FFS to managed care.

- ***Patient navigators or other strategies for assisting beneficiaries with disabilities in managed care could help individuals obtain the services and supports they need.*** Beneficiaries, particularly (but not exclusively) those with mental illness, may need extra assistance obtaining access to the providers and services they need and using services appropriately. The responsibility for providing such assistance could be carried out by states, or by plans through their contracts with states. In either case, resources will be needed to support this function.

### **Monitoring, oversight, and beneficiary protections**

- ***Collection and analysis of encounter data are essential to assessments of access and quality of care and to setting actuarially sound capitation rates.*** While federal law and CMS require states to collect and report encounter data from MCOs – data necessary to analyze and monitor MCO utilization and access levels, variation, etc., and to track costs and support rate-setting efforts – CMS has not enforced this requirement, issued standards, or provided states with technical assistance.<sup>28</sup> As a result, there is no national database to analyze important Medicaid managed care measures. Current federal reporting systems capture only the capitation payments states make to MCOs on behalf of Medicaid enrollees and lack the individual-level utilization data necessary to track and evaluate the access and care that Medicaid enrollees in capitated plans experience, develop a comprehensive picture of Medicaid managed care, and support proper oversight. As states enroll more medically complex Medicaid beneficiaries in managed care, the need for detailed encounter data to assess access, set actuarially sound capitation rates, and hold plans accountable for the payments they receive is increasingly pressing.
- ***Specialized measures of access and quality and robust monitoring efforts are needed to ensure access, coordination, and a satisfactory patient experience across the range of services and supports needed by individuals with disabilities.*** Widely used quality measure sets, such as the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS), do not take into account, or include targeted measures that reflect, the special needs of people with disabilities. Nor have standard quality measures for LTSS been developed, a problematic gap in the context of efforts to integrate management of LTSS and acute health care. In releasing its initial core set of quality measures for adult Medicaid beneficiaries on January 4, 2012, CMS acknowledged the lack of measures for chronic care management and coordination and for those receiving home and community-based services, citing that existing measures in these areas that meet scientific soundness criteria could not be identified; CMS will prioritize these areas for new measure development.<sup>29</sup>

Some states and plans have found ways to address these limitations, for example, by conducting focused monitoring of cervical cancer screening for women who are HIV-positive, dental visits for people with developmental disabilities, pharmacy utilization among people recently diagnosed with depression, rates of hospitalization for pressure sores and falls or fractures among persons with severe physical disabilities, and CD-4 counts, highly active antiretroviral therapy (HAART) utilization, viral loads, and mortality among patients with HIV/AIDS.<sup>30</sup> These tailored approaches have in common that they target monitoring to selected measures of access, utilization, or care that are of key importance for patients with a specified condition or disability.

- ***Careful contracting and state oversight of managed care programs are essential.*** Regulatory and contractual requirements and standards are only as effective as their oversight and enforcement. Contracts between states and managed care plans, including effective incentives for compliance

with contract requirements and effective sanctions for noncompliance, are the principal mechanism for ensuring that plans cover and adequately deliver a defined set of services and supports to Medicaid enrollees and conduct other activities as required by the states. Specificity in these contracts is essential to enable states to hold plans accountable for these obligations.<sup>31</sup> Initiatives such as “secret shopper” surveys to audit the actual availability of network providers to Medicaid beneficiaries, strategic analysis of plan encounter data to monitor and evaluate access and guide rate-setting, and aggressive use of performance measurement and monitoring to drive quality are among the types of oversight that states need to exercise to ensure effective and efficient administration of their programs, including meaningful beneficiary protection. Building and maintaining sufficient state staff capacity to conduct these operations and enforce standards is fundamental.

- ***Federally required grievance and appeals procedures protect beneficiaries in MCOs, but states can take steps to strengthen beneficiary protections.*** Medicaid beneficiaries enrolled in MCOs retain their constitutionally protected due process rights regarding their entitlement to Medicaid benefits. MCOs, and ultimately the state agency, must guarantee and enforce these rights, including the application of federal (rather than MCO) standards for assessing medical necessity, the provision of adequate notice of MCO decisions, and the opportunity for administrative state fair hearings. Further, federal law requires MCOs to establish internal appeals processes regarding denials of coverage of or payment for services, and systems to address grievances related to quality of care and other issues, as well as independent monitoring, analysis, and focused reviews of MCO quality by External Quality Review Organizations (EQROs). Federal MCO rules also require an expedited appeals review process for MCO internal appeals if resolution within the standard timeframe could seriously jeopardize the enrollee’s life or health or ability to attain, maintain, or regain maximum function. However, the appeals procedures are a confusing and burdensome mechanism for beneficiary recourse; adequate payment and provider networks and transparent encounter data provide stronger protection for beneficiaries against underservice.

Beyond the federal requirements, states can provide additional or enhanced avenues for beneficiary grievances and appeals, for example, by establishing a state Medicaid ombudsman program that mediates disputes or advocates on behalf of beneficiaries, and external review programs in which independent reviewers evaluate the merits of grievances and appeals. The effectiveness of initiatives such as these will depend on the resources that states devote to them, outreach efforts that increase beneficiaries’ awareness of their rights and how to exercise them, and beneficiaries’ access to counsel.<sup>32</sup>

## **ENHANCED PCCM AS AN ALTERNATIVE TO RISK-BASED MANAGED CARE**

A number of states, including Oklahoma, North Carolina, Pennsylvania, Indiana, Arkansas, and Rhode Island enroll some beneficiaries with disabilities (as well as others) in PCCM programs that have enhanced care coordination and care management functions.<sup>33</sup> These programs incorporate key strengths typically associated with capitated managed care and use various levers to achieve accountability, while averting the risk of underservice that may be a concern in capitated systems.

- ***Particularly in light of limited state and health plan experience serving Medicaid beneficiaries with disabilities, PCCM may be an attractive alternative to capitated managed care for improving access and care coordination for beneficiaries with disabilities.*** In PCCM programs, states contract

with primary care providers (PCPs) who agree to provide case management services to Medicaid beneficiaries assigned to them, including the location, coordination, and monitoring of primary health services. PCPs must generally meet requirements related to minimum hours of operation, credentials, and responsibility for specialist referrals. Typically, states pay PCPs a small PMPM case management fee in addition to FFS payment for their services, but other approaches include higher FFS payment rates for specific primary care services, partial capitation for a defined set of primary care services, and pay-for-performance. PCPs can be physicians, group practices, or clinics, or, in some states, nurse practitioners, nurse midwives, and physician assistants. A number of states have integrated patient-centered medical homes into their PCCM programs, building in many of the same principles and mechanisms identified with risk-based managed care that are designed to promote more person-centered, coordinated, and integrated care. Enhancements, such as disease management, intensive case management for high cost/high risk enrollees, care management, care coordination, and provider profiling may be carried out by state staff, or states may contract with PCPs, physician-led networks, or outside vendors to perform these activities.<sup>34</sup>

- ***Recent evidence indicates that enhanced PCCM can yield savings, through improved patterns of care rather than price reductions.*** A analysis commissioned by North Carolina and based on Medicaid claims data estimated that, in FY 2010, after adjusting for health status differences between the two groups, PMPM costs for (non-dually eligible) disabled Medicaid beneficiaries in the state's PCCM, Community Care of North Carolina (CCNC), were 3.3% lower than for their counterparts who were not enrolled in CCNC. Estimates for the prior three years showed higher costs for disabled beneficiaries in CCNC, which is consistent with the state's increased focus on this population more recently and the likelihood that, in the short term, PCCM may increase costs due to increased primary care and prescription drug costs.<sup>35</sup>

## Looking Ahead

As Medicaid policy officials seek both to contend with difficult budget pressures and to adopt delivery and payment system reforms designed to improve care and gain more from their Medicaid spending, the current trend toward enrolling Medicaid beneficiaries with disabilities in managed care seems likely to continue. As more states weigh moving in this direction, and as millions of additional low-income adults, including many with disabilities, obtain Medicaid under the Affordable Care Act beginning in 2014, a number of significant challenges and issues stand out. Recognizing that disability has many faces, efforts are needed to better understand the diverse and complex composition of children and adults with disabilities, their correspondingly diverse and complex needs, and the costs associated with meeting those needs. The lack of state and health plan experience serving Medicaid beneficiaries with disabilities in risk-based managed care underscores the need for cautious implementation and measures to mitigate plan risk, strategies to prevent disruptions in access and care, ongoing monitoring and oversight, and strong beneficiary protections. Outreach and education, choice counseling, patient navigation, and other supports designed to accommodate the array of special needs of individuals with disabilities are critical to ensure that beneficiaries understand their options and have timely and adequate access to the care they need. The budgetary and administrative capacity of states to invest sufficient resources in these efforts is also a major concern.

Managed care offers potential to increase access and improve the coordination of care, particularly for those with the most complex needs. However, the actual performance of managed care in serving Medicaid enrollees with disabilities will depend heavily on the specifics of states' managed care contracts, and on many program design and oversight issues. Therefore, states' decisions about how



their managed care delivery and payment systems are structured will matter greatly going forward. Also, the use of timely and accurate encounter data to set actuarially sound capitation rates and assess important access and quality metrics, and the rigor and enforcement of state contracts with MCOs will strongly influence the extent to which goals for improving access and care and reducing costs for Medicaid beneficiaries with disabilities translate into plan accountability for these outcomes. Close study and ongoing evaluation of the experience in California and Texas, two states now moving hundreds of thousands of Medicaid beneficiaries with disabilities into risk-based managed care, have the potential to help identify the attributes of successful models as well as unforeseen challenges, providing valuable guidance as other states move ahead.

This issue brief was prepared by John Connolly and Julia Paradise, both of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

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<sup>1</sup> *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, September 2011. <http://www.kff.org/medicaid/8220.cfm>

<sup>2</sup> Summers L, *Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, October 2011. <http://www.kff.org/medicaid/8243.cfm>

<sup>3</sup> *Medicaid Managed Care: Key Data, Trends, and Issues*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, February 2012. <http://www.kff.org/medicaid/8046.cfm>

<sup>4</sup> *Medicaid's Role for People with Disabilities*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, August 2003. <http://www.kff.org/medicaid/4027.cfm>

<sup>5</sup> *A Profile of Medicaid Managed Care Programs in 2010*, op.cit.

<sup>6</sup> Kronick R et al., *Improving Health-Based Payment for Medicaid Beneficiaries: CDPS, Health Care Financing Review*. Vol. 21, No. 3, Spring 2000.

<sup>7</sup> Duggan M and T Hayford, *Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates*, National Bureau of Economic Research, Working Paper 17236, July 2011.

<sup>8</sup> See state-specific comparisons of Medicaid to Medicare payment rates at <http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4>.

<sup>9</sup> Highsmith N and S Somers, *Adults with Disabilities in Medi-Cal Managed Care: Lessons from Other States*, Medical Policy Institute, September 2003.

<sup>10</sup> *MO HealthNet Comprehensive Review Final Report*, The Lewin Group, April 30, 2010.

<sup>11</sup> *Medicaid Best Buys: Critical Strategies to Focus on High-Need, High-Cost Beneficiaries*. Center for Health Care Strategies, Inc., April 2010.

<sup>12</sup> Palsbo S and M Mastal, *Disability Care Coordination Organizations—The Experience of Medicaid Managed Care Programs for People with Disabilities*, Center for Health Care Strategies, Inc., April 2006.

<sup>13</sup> Highsmith and Somers, op.cit.

<sup>14</sup> *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*, op.cit.

<sup>15</sup> Burns M, *Medicaid Managed Care and Health Care Access for Adult Beneficiaries with Disabilities*, *Health Services Research*, Vol. 44, No. 5, 2009.

<sup>16</sup> California Bridge to Reform Demonstration, CMS Special Terms and Conditions, Sections 56, 57, and 72, see: <http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Publications/CaliforniaSTCs11-2-10.pdf>.

<sup>17</sup> Ibid.

<sup>18</sup> Chimento L et al., *Medi-Cal Beneficiaries with Disabilities: Comparing Managed Care with Fee-for-Service Systems*, The California HealthCare Foundation, August 2005.

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- <sup>19</sup> Palsbo S and P Ho, *Consumer Evaluation of a Disability Care Coordination Organization*, Journal of Health Care for the Poor and Underserved, Vol. 18, No. 4, 2007.
- <sup>20</sup> Collins C et al., *Evolving Models of Behavioral Health Integration in Primary Care*, Milbank Memorial Fund, May 2010. Available at: <http://www.milbank.org/reports/10430EvolvingCare.html>.
- <sup>21</sup> Craven M and R Bland, *Better Practices in Collaborative Mental Health Care: An Analysis of the Evidence Base*. Mississauga: ON: Canadian Collaborative Mental Health Initiative, 2006. Available at: [http://www.ccmhi.ca/en/products/documents/04\\_BestPractices\\_EN.pdf](http://www.ccmhi.ca/en/products/documents/04_BestPractices_EN.pdf).
- <sup>22</sup> Koyanagi C, *Get It Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders*. Washington, DC: Bazelon Center for Mental Health Law, 2004.
- <sup>23</sup> Boyd C et al., *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*, Center for Health Care Strategies, Inc., December 2010.
- <sup>24</sup> *Examining Medicaid Managed Long-Term Service and Support Programs*, op.cit
- <sup>25</sup> Barth J, *The Consumer Voice in Medicaid Managed Care: State Strategies*, Center for Health Care Strategies, March 2007.
- <sup>26</sup> Hibbard J et al., *Is the Informed-Choice Policy Approach Appropriate for Medicare Beneficiaries?* Health Affairs 2001 20(3): 199-203.
- <sup>27</sup> Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, Draft Template Memorandum of Understanding for Capitated Model, July 8, 2011, available at [http://www.cms.gov/smdl/downloads/Financial\\_Models\\_Supporting\\_Integrated\\_Care\\_SMD.pdf](http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf).
- <sup>28</sup> *Medicaid Managed Care Encounter Data: Collection and Use*, Office of Inspector General, U.S. Department of Health and Human Services, May 2009.
- <sup>29</sup> *Medicaid Program: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults*, Final Rule, HHS/CMS, January 4, 2012, see <http://www.gpo.gov/fdsys/pkg/FR-2012-01-04/pdf/2011-33756.pdf>.
- <sup>30</sup> Highsmith and Somers, op.cit.
- <sup>31</sup> Crowley J et al., *Florida's Medicaid Reform Pilot Programs: Challenges with Mental Health Services*, Georgetown University Health Policy Institute, May 2008.
- <sup>32</sup> Stevens B et al., *Beyond Fair Hearings: How Five States Help Medicaid Managed Care Beneficiaries Resolve Disputes with Health Plans*, Office of Disability, Aging, and Long-Term Care Policy, U.S. Department of Health and Human Services, November 2001. Available at: <http://aspe.hhs.gov/daltcp/reports/fairhear.htm>.
- <sup>33</sup> Verdier J et al., *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States*, Center for Health Care Strategies, Inc., September 2009.
- <sup>34</sup> Ibid.
- <sup>35</sup> Cosway R et al., *Analysis of Community Care of North Carolina Cost Savings*, Milliman Client Report prepared for North Carolina Division of Medical Assistance. December 2011.

**Appendix: Summary of Key Research on Risk-Based Medicaid Managed Care and People with Disabilities**

Authors	Title	Publication	Geographic Scope	Study Population	Data and Methods	Outcome Measures	Main Findings
Burns	Medicaid Managed Care and Health Care Access for Adult Beneficiaries with Disabilities	Health Services Research, 2009	National	Medicaid enrollees age 18-64 receiving SSI who are not also eligible for Medicare	County-specific information on mandatory versus voluntary Medicaid managed care for adults with disabilities was merged with Medical Expenditure Panel Survey and the Area Resource File (1996-2004) data. Methods include logit regression, controlling for demographic and other predisposing, enabling, and need-based factors, (e.g. health status).	Usual source of care, travel time to usual source of care, wait time to see usual source of care, problems seeing specialists, and receipt of selected preventive care services	Compared with Medicaid beneficiaries in fee-for-service, Medicaid MCO enrollees in mandatory managed care counties are 24.9% more likely to wait >30 minutes to see a provider, 32% more likely to report a problem accessing a specialist, and 10% less likely to receive a flu shot in the previous year.
Coughlin et al.	Does Managed Care Improve Access to Care for Medicaid Beneficiaries with Disabilities? A National Disability Study	Inquiry, 2009	National	Nonelderly Medicaid beneficiaries receiving SSI (n = 2,856)	County-based measure of managed care enrollment, and pooled data from National Health Interview Surveys (1997-2004). Study intended to be exploratory due to lack of individual level data about MCO enrollment.	Usual source of care when sick and for preventive care; contact with medical doctor, specialist, or nonphysician provider in previous 12 months; flu shot in the previous 12 months; emergency room visit in previous 12 months	Some evidence of improved access under Medicaid managed care; however, gains appear to be largely limited to beneficiaries in urban areas in fully capitated managed care. Little evidence of improved access under primary care case management or, regardless of managed care model, in rural areas.
Burns	Medicaid Managed Care and Cost Containment in the Adult Disabled Population	Medical Care, 2009	National	Working-age Medicaid beneficiaries receiving SSI (n = 1,613)	Medical Expenditure Panel Survey and the Area Resource File (1996-2004). Study uses a repeated observations design comparing beneficiaries who reside in counties with mandatory, voluntary, and no MCOs; uses two-part regression models to estimate the probability and level of expenditure.	Total and service-specific individual monthly Medicaid expenditures	Medicaid MCOs as implemented are not associated with lower Medicaid spending. State Medicaid programs should consider additional policy tools to contain health care expenditures in this population.
Palsbo and Ho	Consumer Evaluation of a Disability Care Coordination Organization	Journal of Health Care for the Poor and Underserved, 2007	Local, Minneapolis-St. Paul, Minnesota	Enrollees in Medicaid disability care coordination organization (DCCO) enrollees in Minneapolis-St. Paul (n = 346)	Survey responses from DCCO enrollees with physical disabilities (2001-2004).	Quality of care, access to care	Respondents reported statistically significant improvements in service coordination, patient education, system-wide disability competency, comprehensive assessment, health visit support, and self-direction of care. Global quality ratings showed statistically significant and sustained improvement over two years, with the percentage of people rating the health system as excellent rising from 7% before enrollment to 44% in the DCCO. Share of people rating primary care physicians as excellent rose from 18% before enrollment to 38% in the DCCO.
Hill and Wooldridge	Informed Participation in TennCare by People with Disabilities	Journal of Health Care for the Poor and Underserved, 2006	Tennessee	Medicaid beneficiaries with disabilities in Shelby County (n = 1,293)	TennCare Disability Survey (1998-1999); uses regression analysis to assess which information sources may be more useful and associated with choosing plans, rather than being assigned.	Usefulness of information, availability of information, whether or not a member chose a plan	Most people with disabilities chose their plans and providers, felt they had enough information to choose a plan, and rated information from their providers as good/excellent. A minority did not know they could choose their plans and providers and reported poor/fair communication with providers. Adults with mental retardation were less likely than other adults with disabilities to seek information. Compared to others, adults with serious difficulty communicating were less satisfied with information from providers.

**Appendix: Summary of Key Research on Risk-Based Medicaid Managed Care and People with Disabilities**

Authors	Title	Publication	Geographic Scope	Study Population	Data and Methods	Outcome Measures	Main Findings
Long and Yemane	Commercial Plans in Medicaid Managed Care: Understanding Who Stays and Who Leaves	Health Affairs, 2005	National	154 commercial plans in 745 counties across 39 states	County Medicaid enrollment data for commercial plans (as of January 2000) from InterStudy. Uses logit models to predict probability that a plan's MMC exit in a county in 2001 was a function of characteristics of the Medicaid program, the plan, and the local health care market in 2000.	Probability of a plan's exit from a county in 2001	Increases in capitation rate levels and capitation growth rates, as well as mental health carve-outs were associated with a lower probability of plan exit. Prescription drug carve outs and mandatory enrollment policies for the SSI population were positively associated with a greater likelihood of plan exit.
Bindman et al.	Preventing Unnecessary Hospitalizations in Medi-Cal: Comparing Fee-for-Service with Managed Care	California Healthcare Foundation, 2004	California	Nonelderly Medicaid beneficiaries (ages 0-64) eligible through SSI or TANF in fee-for-service and managed care	Medi-Cal eligibility data linked to hospital discharge data from the California Department of Health Services (1994-1999); compares preventable hospitalizations among fee-for-service and managed care beneficiaries. SSI and other (CalWorks) beneficiaries analyzed separately. Poisson regression used to model monthly preventable hospitalization rate as a function of the Medi-Cal delivery model, controlling for admission month, admission year, patient age, sex, race/ethnicity, and county of residence.	Rate of preventable hospitalizations	Rate of preventable hospitalizations was one-quarter lower for managed care enrollees than for those in fee-for-service.
Center for Disability Issues and the Health Professions	Adults with Disabilities in Medi-Cal: The Beneficiary Experience	California Healthcare Foundation, 2003	California	Medi-Cal beneficiaries in fee-for-service and both mandatory and voluntary managed care	Qualitative responses from focus groups regarding beneficiaries' experiences in Medi-Cal in 2003.	Understanding of Medi-Cal, access to care, and level of coverage and benefits	Beneficiaries lacked program information, experienced difficulty accessing services, and expressed frustration with the limited scope of benefits.
Nolen	Adults with Disabilities in Medi-Cal Managed Care: Health Plan Practices and Perspectives	Medi-Cal Policy Institute, 2003	California	Health plans serving adult Medi-Cal beneficiaries with disabilities	Qualitative responses regarding plan experiences in Medi-Cal in 2002.	Identifying members with special needs, member education and outreach, benefit design, access to services, care coordination, provider compensation, communication with members, barriers and challenges of serving members with special needs	Plans have reached out to this population through community resource guides, mailings, welcome calls, and orientations; emphasized care coordination through case managers, increased payments for services for members with disabilities; acknowledged that the fee-for-service program offered more extensive benefits; and noted challenges providing adequate equipment, non-emergency medical transportation, overcoming communication barriers, and assessing network limitations.
Higsmith and Somers	Adults with Disabilities in Medi-Cal Managed Care: Lessons from Other States	Medi-Cal Policy Institute, 2003	Massachusetts, New Jersey, Oregon, Pennsylvania	Senior state Medicaid officials, health plan executives, and leaders from consumer organizations	Qualitative interviews (2002-2003)	Priority areas for consideration: managed care model and design; beneficiary enrollment and engagement; financing, rate-setting, and cost containment; network adequacy; care coordination and improvement	Development of a comprehensive managed care program is best at a reasoned pace; quick fiscal relief is not realistic, but long-term savings may be feasible; motivation for programs should be more prevention-oriented, coordinated care that is monitored through an accountable infrastructure.

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