Managed Care for Medicaid Beneficiaries with Disabilities: How Does It Work?

A DISCUSSION FEATURING:

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FORUM SESSION ANNOUNCEMENT

FRIDAY, MAY 6, 2011
11:45AM–12:15PM—Lunch
12:15PM–2:00PM—Discussion

LOCATION
Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
(Across from the Dirksen Senate Office Building)

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OVERVIEW

With the ever-growing concern about costs in Medicaid and across the health care sector, many state officials and others aim to find savings and deliver more efficient and effective care. One possibility in the Medicaid program for achieving these goals is to serve Medicaid’s adult beneficiaries under the age of 65 with disabilities in a managed care setting. In 2008, about 10 million of Medicaid’s 60 million beneficiaries were persons with disabilities. Although they make up a small proportion of the total number of people covered by the program, this vulnerable group has high health care needs and substantially higher per-enrollee costs than other Medicaid beneficiaries. What has been the experience among the states with serving this group of vulnerable people through managed care? In what ways are different states approaching this issue? This Forum session will review these questions and address the challenges facing the nation and states in providing efficient and accessible medical care to persons with disabilities through Medicaid managed care arrangements.

BACKGROUND

Many people think of a low-income child or parent when they picture a person enrolled in Medicaid, and indeed, about three-quarters of Medicaid beneficiaries fall into this category. But each year, a substantial portion of Medicaid’s more than 60 million beneficiaries are adults with disabilities under the age of 65, a group made up of some of the most vulnerable and costly covered by the program. Although they totaled only 18 percent of those covered in 2009, these beneficiaries incurred 44 percent of the program’s costs, according to the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS). Persons with disabilities by definition have high health care needs; they are responsible for a disproportionate amount of expenditures because they incur substantially higher per-enrollee costs for their care, and they use more services than other Medicaid beneficiaries. For example, the estimated average spending on a person eligible for Medicaid on the basis of disability status was about $16,600 in fiscal year (FY) 2009, compared with average spending of $2,900 on non-disabled children, and $4,100 on adults without disabilities under 65 years of age.¹ Expenditures for persons with disabilities under age 65 are the fastest growing segment of Medicaid costs.²
This group of beneficiaries with disabilities is a diverse population with a wide range of conditions and limitations. Many have a variety of complex diagnoses and their conditions span a range of severity levels. Included are people with physical limitations like spinal cord injuries, persons with developmental and intellectual challenges, those with behavioral health diagnoses, and people with multiple chronic conditions. The increasing number of people with chronic conditions and the amount of care needed grows each year; for example, people with five or more chronic conditions see about 14 physicians per year. Even if persons with disabilities have a stable chronic condition, they may be more at risk of infection, falls, and other complications and difficulties. Regardless of diagnosis, all adults with disabilities are at risk for experiencing significant and costly medical problems and associated needs for supportive services.

To qualify for Medicaid coverage, an individual must have a permanently disabling condition. Persons with a disability may come into the Medicaid program if they qualify for the federal Supplemental Security Income (SSI) income support program, which in most states grants automatic eligibility for Medicaid. States’ policies with regard to eligibility vary, however. Some states, for example, cover adults with high health care costs through a Medicaid medically needy program, or they may cover higher income persons with disabilities who are working but need Medicaid’s health benefits to continue employment.

**MEDICAID MANAGED CARE**

For decades, Medicaid programs have provided services to beneficiaries through various kinds of managed care arrangements. Managed care in Medicaid began in the 1970s as experimental programs in a few states, almost exclusively to serve children and families. Initially, state Medicaid directors moved to this form of delivery to provide better access to care and to provide savings and more predictability in budgeting Medicaid program costs. The enactment of a statutory waiver program in 1981 allowed more extensive use of managed care, and the phenomenon began to grow. The pace of managed care expansion in Medicaid picked up in the 1990s and accelerated further during the past decade. For example, in 1999, 56 percent of all beneficiaries were served in managed care arrangements; ten years later, in 2009, the percentage had grown to nearly 72 percent of Medicaid beneficiaries nationally. Only two states, Alaska and Wyoming, reported providing no care through managed care arrangements.
State administrators employ a variety of approaches to managing care for their beneficiaries. One model involves contracting for care at a capitated rate with health maintenance-like organizations that have a closed panel of providers. Another uses gate-keeper models of care with primary care physicians assisting with management duties, as in primary care case management. Hybrid approaches to managing care under Medicaid capitate some services, carve out others, or manage some individuals or groups in unique or locally home-grown ways.

Historically, states usually made participation of disabled Medicaid beneficiaries voluntary in managed care arrangements. That is, a person with Medicaid coverage who has a disability could choose whether to use capitated care or fee-for-service arrangements to receive care. As experience with a variety of forms of managed care delivery grew, more states became interested in managing service delivery to all Medicaid beneficiaries, including adults with disabilities, even on a mandatory basis. There were particular concerns, however, about the potential for underserving persons with disabilities in this way, since they may need many specialized health care services as well as other long-term services and supports. In the 1997 Balanced Budget Act (BBA), managed care was made a more regularized, Medicaid state plan benefit (instead of just a waiver option) that states could mandate as a way to cover most types of Medicaid eligibles. However, it was not until the Deficit Reduction Act (DRA) of 2005 that states were allowed to mandate—without obtaining a waiver—that persons with disabilities use managed care delivery systems.

Regardless of the vehicle, through waivers, or BBA and then DRA authority, states have increasingly served more and more beneficiaries in managed care arrangements, including persons with disabilities. As with coverage for other population groups, states were prompted by both the desire to provide better access to services and to concomitantly control costs and enhance cost predictability. As required by the BBA and DRA, states have adopted policies and contract provisions that require managed care providers to measure performance and insure that quality and other standards are met. These new requirements demand greater transparency and call for careful state oversight of managed care.

Recent interest in coverage of additional people with disabilities under managed care arrangements seems to be driven by the desire for cost containment. However, national studies have been equivocal
about overall savings, particularly for persons with disabilities, and more work is necessary before definitive information on savings will be available. As with many questions in Medicaid, state programs differ substantially, and so may each state’s experience with these efforts.

SESSION
This Forum session will review the challenges facing the nation and states in providing efficient and accessible medical care to persons with disabilities through Medicaid managed care arrangements. Speakers will review the background and history of coverage through managed care, studies that have evaluated states’ experiences with managed care for persons with disabilities, the different types of managed care used by states, and the problems encountered in delivering care in this way. Questions related to ensuring access and containing costs will be addressed.

SPEAKERS
Paul Saucier is a director in the Community Living Systems Group at Thomson Reuters. He specializes in research related to public programs for older persons and persons with disabilities and has conducted numerous qualitative studies for a number of organizations. Izanne Leonard-Haak is acting deputy secretary in the Pennsylvania Department of Public Welfare, where she manages the state’s Medicaid program. A long-time Pennsylvania Medicaid program employee, Ms. Leonard-Haak previously served as policy director and also in Washington in the federal Medicaid program before joining the state of Pennsylvania. Christopher Perrone serves at the California HealthCare Foundation as deputy director for the Health Reform and Public Programs Initiative. Mr. Perrone worked previously as director of the Medi-Cal Policy Institute and in Massachusetts’ Medicaid program.

KEY QUESTIONS
* How many states currently cover adult beneficiaries under age 65 with disabilities through managed care?
* What types of managed care are involved? Fully or partially capitated plans, primary care case management, other types of care management? How prevalent are the different arrangements?
• Do research studies indicate whether managed care arrangements provide increased access to care for people with disabilities? What is the evidence on reduction of costs through the use of managed care for this vulnerable group of people? What are other reasons for states to choose this model of care delivery for persons with disabilities?

• What type of managed care is provided in Pennsylvania and California, and to what groups of people? Why did Pennsylvania and California adopt managed care for providing services to people with disabilities?

• What is the nature of the experience in California and Pennsylvania with managed care for this group? What safeguards are in place to monitor the experiences of persons with disability being served in managed care programs?

• What challenges did Pennsylvania encounter in initiating managed care for persons with disabilities, and what challenges are present now? What does the state see as the strengths and weaknesses of the Medicaid managed care program?

• What have California HealthCare Foundation studies revealed about access and quality of care for people enrolled in managed care delivery systems? What about for persons with disabilities?

• How will the coming enrollment of more persons with disability into Medi-Cal managed care arrangements be initiated and monitored?

ENDNOTES


4. Another federal income support program, Social Security Disability Income (SSDI), is available to people with disabilities and those who are eligible for the program through work credits paid into this trust fund. SSDI beneficiaries must wait two years after their income benefit begins to receive health benefits through Medicare. If those people are low-income and meet other requirements, they may qualify for Medicaid during the waiting period, and they may stay on Medicaid when their Medicare begins and become “dual eligibles,” that is, eligible for both Medicaid and Medicare. Dual eligibles are not discussed herein; in this session, the Forum will focus on coverage of the disabled rather than dually eligible beneficiaries. For further information, see...
