Managed Care for Medicaid Beneficiaries with Disabilities

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NATIONAL MEDICAID MANAGED CARE ENROLLMENT, 2009

[Bar chart showing Medicaid Managed Care Enrollment as of June, 2009]

Original Medicaid: 14.3 millions
Managed Care: 36.2 millions

CMS: “Medicaid Managed Care Enrollment as of June, 2009”
https://www.cms.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp
TYPES OF MEDICAID MANAGED CARE

• Comprehensive risk contracts: capitation for a wide range of services (e.g., primary, acute, behavioral, dental)

• Carve-out risk contracts: capitation for one type of service (most common are behavioral, dental, transportation)

• Primary Care Case Management: PCP receives monthly PMPM payment for care management; services are reimbursed FFS

• Patient-centered medical home (PCMH) can and does occur within risk or PCCM arrangements
RISK-BASED MMC IS THE DOMINANT FORM

CMS: Derived from “Number of Managed Care Entity Enrollees by State as of June, 2009”
https://www.cms.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp
ENROLLMENT OF ADULTS WITH DISABILITIES

• National enrollment is not reported by eligibility category.

• CMS does publish the *National Summary of State Medicaid Managed Care Programs* which lists all MMC programs and the populations they serve.

• My review of the 2009 *Summary* identified 46 states that enroll adults with disabilities.

• Only Connecticut, Mississippi, West Virginia and Wyoming do not.

• In many states, adults with disabilities are enrolled in more than one program.
POTENTIAL BENEFITS OF MANAGED CARE FOR PERSONS WITH DISABILITIES

• Better access to primary care/medical home
• Better management of chronic conditions
• Diversion from emergency rooms
• Better management of hospital stays and prevention of readmissions
• Better care coordination
CONCERNS ABOUT MMC AMONG BENEFICIARIES WITH DISABILITIES

- Inadequate specialty capacity
- Loss of relationships with existing providers
- Restrictions on DME and supplies
- Loss of control, particularly among persons who self-direct services
- Medical model
EVIDENCE IS MIXED

• Very few recent studies that focus on persons with disabilities; mixed results

• Increased likelihood of having a regular source of care in 2 national studies (Coughlin et al, 2009; Burns, 2009) but managed care members more likely to report >30 minute wait time in regular provider’s office, and difficulty accessing specialty care (Burns, 2009)

• Increased use of emergency department, hospital admissions, ambulatory services and prescription drugs in 2 CA counties (Losasso and Freund, 2000)

• Improved access to preventive, primary and specialty care, and reduction in hospital and emergency department in a sample of disability-oriented contractors (Palsbo and Mastal (2006)
LESSONS LEARNED

• Cultivate long term collaborative relationships with contractors

• **Measure performance**, which requires early attention to data gathering and analysis

• **Engage stakeholders** early and continuously

• Build effective administrative infrastructure

• Adapt to local conditions

(Hurley & McCue, 2000; Verdier & Hurley, 2004; Schneider et al., 2004; Barth 2007; Bella et al., 2006)
REFERENCES


CONTACT INFORMATION

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