

Mandated Managed Care for Blind and Disabled Medicaid Beneficiaries in a County-Organized Health System: Implementation Challenges and Access Issues

Zeina C. Hawkinson, PhD; and Janice E. Frates, PhD

Abstract

Objectives: The challenges of Medicaid managed care organizations that serve blind and disabled members are reviewed. Beneficiary satisfaction and access to care are assessed, and access problems are identified and resolved or minimized to the greatest degree possible.

Study Design: Formative evaluation consisting of a mailed survey and follow-up telephone outreach contacts.

Patients and Methods: A written survey was sent to more than 18,000 Supplemental Security Income (SSI) beneficiary members who were blind or disabled, with 5574 recipients responding. Of these, 1981 members identified issues that warranted 2106 follow-up telephone calls.

Results: Survey responses showed that beneficiaries had limited experience with managed care and were generally satisfied with access to primary care. The healthcare system used the study findings to develop focused training programs and materials, to initiate a special needs liaison program, and to revise guidelines to simplify and standardize authorization procedures for obtaining medical supplies and repairing equipment.

Conclusions: Factors found to be associated with the success of a Medicaid managed care program serving blind and disabled beneficiaries include educating the members and providers for better under-

standing of managed care, incorporating collaborative service improvement activities, and documenting trends.

(*Am J Manag Care* 2000;6:829-836)

The number of states seeking to control Medicaid program costs and improve beneficiary access to care by implementing managed care delivery systems increases each year.¹ The proportion of the total US Medicaid population enrolled in a managed care organization has increased from just under 10% in 1991 to 48% in 1997.² After initially focusing efforts on implementing managed care for low-income families, states are now directing more attention to using managed care for beneficiaries whose eligibility derives from the Supplemental Social Security Income (SSI) program. This program includes individuals who are older than 65 years of age as well as those who are blind or disabled. In most states, beneficiaries must meet certain program criteria for disability and maximum allowable financial resources. Eligibility criteria are based on the ability of an individual to function in daily life and the existence of a disabling diagnosis or condition.

State Medicaid programs and their contracting managed care organizations face formidable challenges serving SSI beneficiaries who are blind and disabled because these individuals have multiple, complex medical needs that are typically treated by several specialty providers. Although these individuals comprise only 18% of all Medicaid beneficiaries in the United States, they account for 44% of Medicaid vendor payments because of their high need for specialty medical services. In California, blind and dis-

From Kaiser Permanente Health Plan, Pasadena, CA (ZCH) and the Health Care Administration Program, California State University Long Beach, Long Beach, CA (JEF).

This study was conducted and funded by CalOPTIMA, Orange, CA.

Address correspondence to: Janice E. Frates, PhD, 1863 Braemar Way, Newport Beach, CA 92660. E-mail: jefrates@home.com.

abled individuals constitute 16% of beneficiaries and account for 47% of payments in MediCal, the Medicaid program in California.^{3,4}

Not only do blind and disabled Medicaid beneficiaries account for a disproportionately high share of program expenditures, they are likely to remain Medicaid beneficiaries their entire lives because they are eligible to be considered permanently disabled. Thus, the potential to contain and possibly reduce program expenditures by using managed care systems for these high-cost beneficiaries is extremely attractive if quality of care can be assured. The Health Care Financing Administration has proposed a value-based purchasing strategy that considers factors other than the lowest price for using Medicaid managed care systems, recognizing that a singular focus on saving money could put the health and well-being of individuals with special needs at undue risk.⁵

This paper summarizes the early experience of a California county-organized health system (COHS) serving blind and disabled beneficiaries who were involuntarily enrolled in a Medicaid managed care plan. This formative evaluation was designed to identify unanticipated problems in the implementation process and generate systemic improvements to enhance program operations.⁶ Other Medicaid managed care organizations can use this information for better understanding of the unique needs of this population to better manage the care of these members.

... BACKGROUND ...

Previous Research

In 1995, The Kaiser Foundation Commission on the Future of Medicaid reviewed 139 articles, books, and reports on the use of managed care programs for Medicaid populations. The Commission's report found that Medicaid beneficiaries generally have a higher need for more specialized services and enabling assistance than other beneficiaries in a managed care system to overcome access barriers such as lack of transportation and language or cultural differences. Beneficiaries with severe disabilities are more likely to depend on specialist care, even for services that are considered primary care.⁷

The federal government has funded numerous studies on the impact of Medicaid managed care on both beneficiaries and providers. A 1996 General Accounting Office (GAO) report expressed reservations about the suitability of managed care for disabled beneficiaries as well as the potential for managed care plans to disrupt the network of providers

that disabled persons have assembled over time.⁸ Another GAO research team found that clinical studies often focused on the general Medicaid population as a whole, with less frequent focus on populations that may not fare as well with managed care, such as people with disabilities or chronic conditions.⁹ When examining California's program, the GAO noted that many Medicaid providers reported problems participating in MediCal managed care plans.¹⁰ This is not unusual, as the experience of states in providing care for disabled beneficiaries is limited; of 17 states with managed care programs for the disabled, 12 had fewer than 20% of their Medicaid beneficiaries enrolled. In addition, only 1 of the 6 state programs mandating that some or all of their disabled beneficiaries enroll in managed care plans was more than 3 years old.¹¹

One study echoed these concerns while indicating that persons with disabilities have much to gain from a fully integrated delivery system.¹² Research indicates that most disabled Medicaid recipients secure specialized care from academic medical centers or clinics organized by disability-specific organizations that are not active members of managed care networks; these organizations have not accommodated themselves to risk management or capitated payment. Disabled beneficiaries bring atypical and complex service needs to managed care and may also introduce an element of unwelcome operational and financial risk. On the other hand, most managed care organizations that enroll persons with disabilities have limited experience with severely disabled members. These organizations are not likely to have strong relationships with providers of specialized ancillary services that persons with disabilities use, such as wheelchair manufacturers, home infusion therapists, and personal care attendants.¹² A 1996 national survey of Medicare health maintenance organization (HMO) members that included disabled Medicaid beneficiaries who were not elderly found that although most of these members did not experience access problems, they were more likely than persons who were not disabled to have such problems.¹³

The literature highlights concerns that blind and disabled Medicaid beneficiaries may not be well served by managed care delivery systems and underscores the need to better understand the challenges of serving this vulnerable population.

The MediCal Managed Care Initiative

In 1993, the California Department of Health Services began a major expansion of the MediCal

managed care program with the primary purpose of improving beneficiary access to care, which was often lacking in the fee-for-services environment.¹⁴ Between 1994 and 1997, this expansion initiative resulted in the proportion of enrollees in managed care plans increasing from 17% to 36% of the total MediCal beneficiary population.¹⁵

California counties adopted a variety of program options to fulfill the state mandate to expand MediCal managed care participation. Five counties (San Mateo, Santa Barbara, Solano, Orange, and Santa Cruz) developed COHSs, local agencies that contract with the state Medicaid agency to deliver care to all eligible beneficiaries residing within their boundaries. Among the 5 COHSs, 58,600 enrollees are blind and disabled. Orange County has the largest population of all the COHS counties, with more than half of all blind and disabled COHS managed care beneficiaries in the entire state enrolled in this system.¹⁶

The CalOPTIMA Program

CalOPTIMA began operations as a COHS in October 1995 with 180,000 beneficiaries of the Aid to Families with Dependent Children (AFDC) program. In February 1996, 55,000 individuals who were elderly, blind, and disabled were added to this health system. More than half of all CalOPTIMA members receiving SSI were eligible because of mental disability, including mental retardation, autistic disorder, schizophrenia, paranoia, and, under certain circumstances, substance abuse. The remainder were eligible based on physical disabilities, such as blindness, muscular dystrophy, cerebral palsy, Parkinson's disease, brain tumors, rheumatoid arthritis, osteoporosis, and chronic heart disease. With the enrollment of 10,000 long-term care, foster care, and share-of-cost beneficiaries in April 1996, the health system now covers all Medicaid beneficiaries in Orange County, with a membership of about 230,000 as of January 1997.

The CalOPTIMA Health System Structure. CalOPTIMA has contracted with 2 distinct types of health networks: HMOs, the traditional commercial licensed entities in California that assume full risk for members; and physician/hospital consortia (PHCs), which are physician groups contractually aligned with at least 1 hospital to provide services to CalOPTIMA health system members. Currently, the health system contracts with 6 HMOs and 13 PHCs, incorporating more than 1300 primary care physicians (PCPs). These 19 health networks enrolled 77% of all beneficiaries and 58% of blind

and disabled beneficiaries.¹⁶ The health system made extensive efforts to ensure that the full range of traditional MediCal providers for blind and disabled beneficiaries participated in health networks and PHCs.

CalOPTIMA Direct. Approximately 50,000 Orange County MediCal beneficiaries in a given month either are awaiting assignment to a health network or belong to special aid groups whose members cannot be assigned to health networks. These members receive care from CalOPTIMA Direct. Essentially a fee-for-service system open to all MediCal providers, this plan employs managed care tools such as prior authorization, concurrent review, and medical case management to evaluate medical necessity and coordinate and improve care. Table 1 summarizes the differences among the traditional MediCal program, CalOPTIMA Direct, and contracted health networks. As of December 1996, 32,395 blind and disabled members were enrolled in the CalOPTIMA health system; 13,902 (43%) were in CalOPTIMA Direct, while the remaining 18,493 enrollees (57%) were distributed among the health networks.

... OBJECTIVES AND METHODS ...

In January 1997, CalOPTIMA began an early evaluation and member outreach program for blind and disabled members, with 3 principal objectives:

- To assess on an aggregate basis whether blind and disabled members experience difficulty accessing specialized services in the managed care health networks with which the health system contracts.
- To follow up and address access issues on an individual basis depending on the member's questionnaire response.
- To minimize or eliminate, if possible, systemic access barriers based on both the questionnaire and the individualized follow-up findings.

The first stage of the study was a mail survey sent to more than 18,000 blind and disabled MediCal members, all of whom were enrolled in the health networks. The questionnaire was printed in English, Spanish, and Vietnamese. It was not distributed in Braille because of the health system's experience of very limited requests for materials made available in Braille. The majority of beneficiaries considered to be legally blind have limited sight-reading ability and do not read Braille, while beneficiaries who are truly blind have a sighted caregiver or guardian.

Each returned survey generated an acknowledgment card and an entry into a database. The case management department then reviewed and triaged the surveys according to the following criteria:

- Is an urgent medical condition present? (Case management nurses provided assessment and follow-up services to 167 members whose responses indicated an urgent need for care.)
- Did the member specifically request a return telephone call? (968 respondents [18% of total] requested a call back.)
- If the member did not request a return telephone call, did the responses on the questionnaire indicate that follow-up assistance might be necessary or beneficial?

The second stage of the study involved telephone outreach to members whose responses met the second and third criteria. Member Services staff made 2106 outreach calls to 1981 members (or 13% of those in the health networks) to identify other service needs and to obtain additional information on member satisfaction with and understanding of the new managed care delivery system. The outreach staff also documented the nature of member issues

and the outcomes of these phone calls. The Figure shows a flowchart of this member outreach process.

... RESULTS ...

Mail Survey Responses

Table 2 shows the overall results of the outreach questionnaire. The distribution of responses by blind and disabled members are representative of their proportions in the total beneficiary population with respect to aid category (eg, blind versus disabled and community versus long-term-care facility residents).

Questionnaire responses indicated some problems with accessing specialists, obtaining medical supplies, and obtaining or repairing medical equipment. The majority of members did not have previous experience with managed care, had accessed their current PCPs, and felt satisfied with the physicians they had chosen.

Telephone Follow-up and Outreach Results

The issues most frequently identified during the telephone outreach contacts concerned access,

Table 1. Managed Care Continuum*

Managed Care Features	Traditional MediCAL	CalOPTIMA Direct	CalOPTIMA Contracted Health Networks
Benefits	MediCAL benefit package	MediCAL plus CalOPTIMA	MediCAL plus CalOPTIMA
Risk	No risk	CalOPTIMA at risk	Health network at risk
Provider payment	Fee for service	Fee for service	Capitated
Provider	Any qualified provider	Any qualified provider	Closed network
Primary care	No assigned PCP	Identified provider	Assigned provider
Coordination of care	No case management	Case management	Case management
Managed care	No managed care	Partially managed care	Managed care



 Managed Care Continuum

*From left to right, programs feature increasing levels of managed care techniques. PCP = primary care physician.

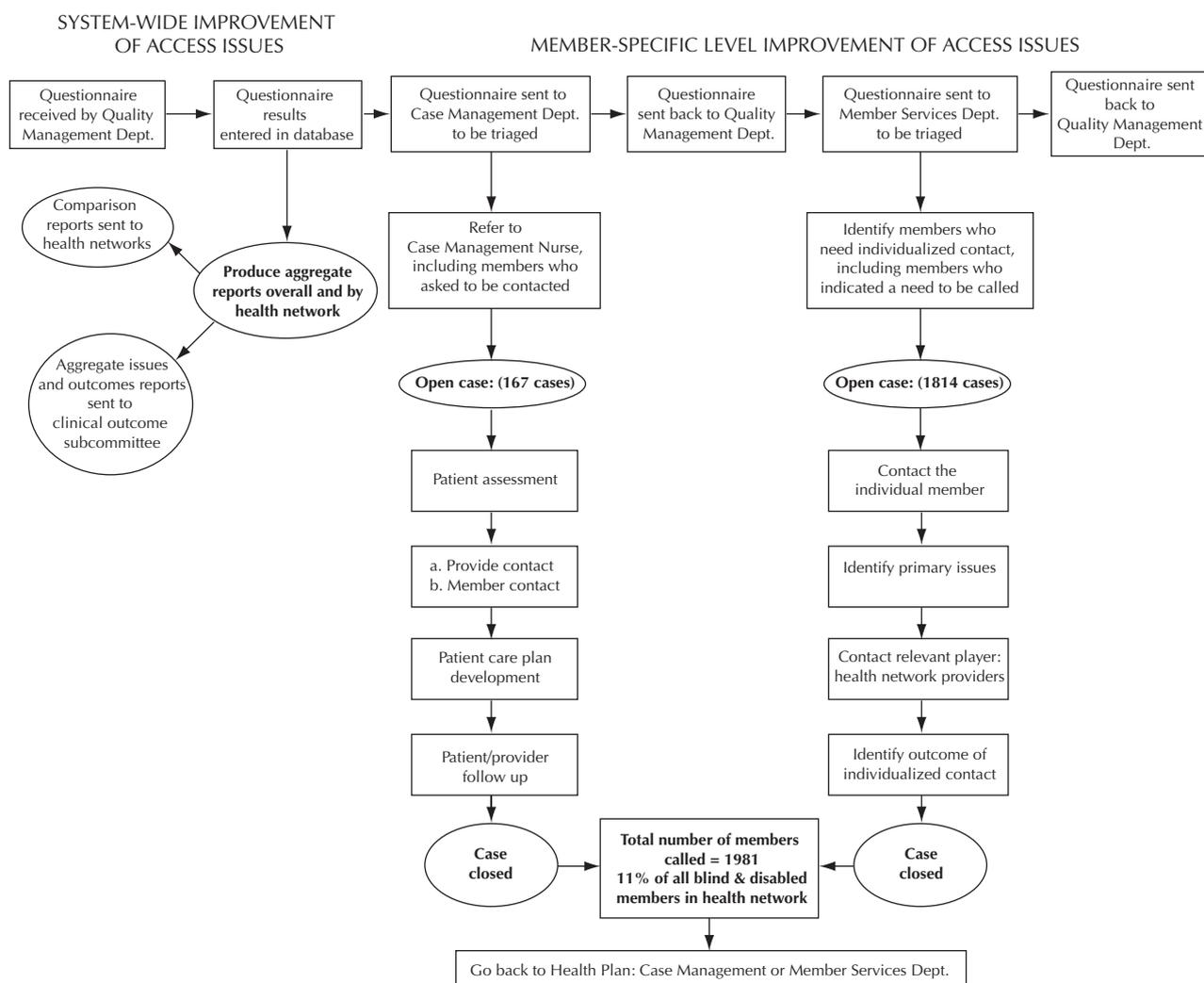
enrollment, healthcare delivery, and education needs. Provider access was an issue in 45% of calls. Enrollment issues involving member requests to change health networks or doctors accounted for 23% of calls; the majority of the members who switched did so to enhance their selection of doctors (20%), to see a provider closer to home (15%), or because of dissatisfaction with the quality of medical care or the provider (5%). Of the 1981 members contacted by telephone, only 125 (6%) actually changed health networks or providers. Healthcare service delivery and equipment needs were issues in 13% of outreach calls. While 12% of calls dealt with

members who expressed a need for education, 83% of respondents had no prior experience in managed care and 62% of all calls involved educating a member on navigating a managed care environment in addition to dealing with another issue specific to that member.

... DISCUSSION ...

Analysis of the study results revealed some methodological weaknesses, identified several personnel and provider issues that required resolution on a

Figure. Outreach Process for Blind and Disabled Members



case-by-case basis, and indicated several areas where the health plan could make systemic improvements.

Study Limitations

Determining how well the survey responses reflected ethnicity was not possible for 2 reasons. First, member records do not contain an ethnic or language identifier, and second, ethnicity and language preference are not necessarily related as English is the primary language for many ethnic minority members.

The 30% overall response rate to the written questionnaire, while less than the health system hoped to obtain, is relatively strong for a mail survey.¹⁷ It may also reflect resentment on the part of the beneficiaries of the involuntary transition to a managed care system. Other researchers studying the Medicaid population have noted a historic mistrust of healthcare research.¹⁸

Problem Resolution

CalOPTIMA's interventions with members resolved individual problems identified through the telephone

follow-up and outreach calls. The 4 principal issues for which Member Services and Case Management staff provided assistance are discussed below.

Provider Access. Members with identified access issues received advice and instructions on how to choose a PCP, obtain a referral to a specialist, or allow a specialist who has experience with the member's disability to serve as the PCP for that patient.

Enrollment Issues. In 50% of calls involving enrollment issues, Member Services intervention focused on helping members learn how to access providers in a managed care environment. Some members expressed general opposition to managed care systems, especially having to access specialty care through the PCP, although most members were satisfied with the services they were receiving and many also expressed appreciation for the outreach process.

Healthcare Service Delivery. Half of these call recipients obtained information and assistance regarding coordination of care and benefits interpretation as well as help from both Case Management and Member Services staff in requesting and obtaining durable medical equipment (DME) and supplies.

Table 2. CalOPTIMA Member Outreach Questionnaire—Blind and Disabled: Summary of Overall Results

Question	Response Rate (%)		
	Yes	No	NA or None
Have you been to your healthplan primary care doctor since becoming a CalOPTIMA member?	84	14	2
Have you had difficulty getting a doctor's appointment in your health plan?	10	80	10
Have you had difficulty getting to see a specialist in your health plan?	17	55	28
Are you comfortable with your health plan primary care doctor?	82	12	6
Have you had difficulty getting the medical equipment your doctor ordered?	6	6	88
Have you had difficulty getting your medical equipment fixed?	3	32	65
Have you had difficulty getting your medical supplies?	5	33	62
Before becoming a CalOPTIMA member, were you ever a member of an HMO or managed care plan?	17	80	3

Total number of members responding: 5574 (response rate 30%).
NA = not applicable.

Education. Most of the members who specifically requested education (69%) obtained information on how the new county health system functioned and what educational programs were available to them as part of their managed care benefits. The outreach program offered the health plan an opportunity to further educate members and their guardians and advocates about a type of healthcare delivery system with which they were unfamiliar while learning about and taking action on a variety of access issues.

Improvement Opportunities and Actions

In the year following the survey and outreach program, CalOPTIMA developed and implemented several service improvement initiatives for blind and disabled members based on the study findings. These initiatives focus on access and quality. In addition, they emphasize educational and collaborative activities of the medical and community service providers with the shared beneficiary population.

Standardized Utilization Guidelines. This study found that a significant obstacle at the health network level was the requirement for monthly authorization of ongoing medical supplies for patients with chronic conditions. The Special Needs Work Group collaboratively proposed a 6-month supply authorization policy applicable for all networks; this proposal has encouraged the health system to further simplify and standardize the authorization processes for items and services ranging from incontinence supplies to long-term speech therapy.

Quality Management Health Network Work Group (QMHNWG). This group is a forum for health system and network administrators, medical directors, and case managers to improve the access to and continuity of care for disabled members. Pursuant to its recommendation, the health system modified its policies to allow specialist physicians with expertise in a particular disability to serve as primary care providers for some blind and disabled members.

Enhanced Case Management. The health system adopted the Case Management Society of America (CMSA) Standards of Practice for Case Management for contracting health networks' case management programs as well as its own and worked intensively with providers to ensure the use of these standards. CalOPTIMA disseminated the standards to health networks prior to case management focus reviews then provided feedback to the networks during the reviews on ways to enhance their programs; written confirmations of noncompliance were provided and requests for corrective action plans were considered.

The health system regularly updates and disseminates a list of designated case management service staff in each network and the health system to members and advocacy agencies.

Focused Education to Health Networks and Providers. In June 1997, the health system conducted a conference for providers and community agencies titled "Effectively Serving People With Disabilities Through MediCal Managed Care." Program content included a review of challenges in serving and managing care for persons with disabilities and special needs; transitioning populations from fee-for-service to managed care; instituting guidelines for building an effective network; and a special clinical track for primary care providers. In July 1997, the health system designed and delivered 2 training sessions for health networks on the prior authorization procedures and the MediCal benefit set and scheduled quarterly follow-up technical support sessions. Participants rated these training sessions favorably and suggested other topics for future programs.

Disability Community Liaison (DCL) Program. In August 1997, the health system adapted the DCL program from a similar program in Arizona. Staff with experience delivering health and social services to disabled people were assigned by CalOPTIMA to contract with health networks to assist in the coordination of care with vendors and community agencies. These staff members provide beneficiaries with special assistance navigating the managed care system, ensure timely and appropriate referrals, and assist PCPs in fully understanding individual member needs.

Community Resource Guides. CalOPTIMA developed a comprehensive guide and distributed it to hundreds of primary care providers to assist them in coordinating services for special needs patients with mental health and dental providers and community service organizations for the disabled. The case management department provided health networks and members with a smaller list of the community resources most frequently used by special needs members.

... CONCLUSIONS ...

CalOPTIMA undertook a formative evaluation to proactively address community concerns and learn from its early implementation experience how to better serve its involuntarily enrolled blind and disabled beneficiaries. While the transition of this large Medicaid population to managed care was not exceptionally problematic, issues that arose were generally

consistent with concerns noted in recent literature. The principal lessons learned from CalOPTIMA's member survey and outreach study concern access, education, collaboration, and tracking.

Access was the most problematic issue for members and presented the best opportunity for improvement in the health system. Managed care delivery systems serving SSI beneficiaries need to proactively monitor access to specialists and ancillary and equipment providers. In addition, these systems should be prepared to develop standardized utilization guidelines, case management standards, and audit tools.

The educational program needs to be multidirectional, inclusive of and tailored to providers, members, and staff from community-based organizations and the administering organization. Content should focus on the managed care delivery system and its operating procedures.

As with any new managed care system, Medicaid beneficiaries, providers, and community advocacy agencies will be alert to onset of new problems. To enlist their cooperation in resolving those problems is both a challenge for and a responsibility of the health system as the administering local agency.

Managed care organizations serving the SSI beneficiary population need to collect data from members, health networks, and providers to document trends for benchmarking and for determining the best practices at both the provider and health network levels.

The next frontier for Medicaid managed care is to transition the SSI beneficiary population, which accounts for a disproportionately large share of program expenditures. While the challenges are many, the opportunities for more effectively deploying increasingly scarce public resources for this highly vulnerable population are great.

... REFERENCES ...

1. US General Accounting Office. *Spending Pressures Drive States Toward Program Reinvention*. Washington, DC: US Government Printing Office; April 4, 1995. Publication GAO/T-HEHS-95-129.
2. US Department of Health and Human Services, Health Care Financing Administration. Medicaid managed care enrollment report, summary statistics as of June 30, 1997. Available at: <http://www.hcfa.gov/medicaid/trends97.htm>. Accessed October 9, 1998.

3. US Department of Health and Human Services, Health Care Financing Administration. Medicaid recipients by basis of eligibility and by state: Fiscal year 1997. Available at: <http://www.hcfa.gov/medicaid/MCD9702.htm>. Accessed June 19, 1999.
4. US Department of Health and Human Services, Health Care Financing Administration. Medicaid medical vendor payments by basis of eligibility of recipient and by state: Fiscal year 1997. Available at: <http://www.hcfa.gov/medicaid/MCD97T09.htm>. Accessed June 19, 1999.
5. US Department of Health and Human Services, Health Care Financing Administration, Center for Medicaid and State Operations. *Key Approaches to the Use of Managed Care Systems for Persons With Special Needs*. Available at: <http://www.hcfa.gov/medicaid/smd-snpf.htm>. Accessed July 17, 1999.
6. Patton MQ. *Utilization-Focused Evaluation*. 3rd ed. Thousand Oaks, CA: SAGE Publications; 1997:67-69.
7. Rowland D, Rosenbaum S, Simon L, Chait E. Medicaid and managed care: Lessons from the literature. San Francisco, CA: Kaiser Commission on the Future of Medicaid; March 1995.
8. US General Accounting Office. *Serving the Disabled Challenges State Programs*. Washington, DC: US Government Printing Office; July 1996. Publication GAO/HEHS-96-136.
9. US General Accounting Office. *Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort*. Washington, DC: US Government Printing Office; May 16, 1997. Publication GAO/HEHS-97-86.
10. US General Accounting Office. *Medicaid Managed Care: Delays and Difficulties in Implementing California's New Mandatory Program*. Washington, DC: US Government Printing Office; October 1, 1997. Publication GAO/HEHS-98-2.
11. US General Accounting Office. *Medicare and Medicaid: Meeting Needs of Dual Eligibles Raises Difficult Cost and Care Issues*. Washington, DC: US Government Printing Office; April 29, 1997. Publication GAO/HEHS-97-119.
12. Tanenbaum SJ, Hurley RW. Disability and the managed care frenzy: A cautionary note. *Health Aff* 1995;14(4):213-219.
13. Gold M, Nelson L, Brown R, et al. Disabled Medicare beneficiaries in HMOs. *Health Aff* 1997;16(5):149-162.
14. Moore DJ Jr. Blood from a stone. *Modern Healthcare* 1996;26:28-32.
15. California Department of Health Services. *1998 Managed Care Annual Statistical Report*, Table 1.1A. Available at: <http://www.dhs.cahwnet.gov/org/admin/ffdmb/messindex.htm>. Accessed October 8, 1998.
16. CalOPTIMA Membership Report, January 1997.
17. Alreck PL, Settle RB. *The Survey Research Handbook*. Homewood, IL: Richard D. Irwin; 1985:45.
18. Chaudry RV, Brandon WP, Schoeps NB. Medicaid recipients' experience under mandatory managed care. *Am J Manag Care* 1999;5:413-426.