



Medi-Cal Beneficiaries with Disabilities: Comparing Managed Care with Fee-for-Service Systems

Introduction

As part of his efforts to close California's budget gap, Governor Schwarzenegger has proposed fundamentally restructuring Medi-Cal, the state's \$34 billion health care program for low-income children and families, adults with disabilities, and elderly individuals. A central element of the governor's proposal is to expand mandatory enrollment in Medi-Cal managed care, including among beneficiaries with disabilities. In January 2005, approximately 6.5 million people were enrolled in Medi-Cal, including 1 million non-elderly beneficiaries with disabilities.¹ Currently, 20 percent of non-elderly adults with disabilities are enrolled in Medi-Cal managed care. The governor's proposal would increase the number of disabled beneficiaries enrolled in managed care from 208,000 to 699,000.²

What would an expansion of Medi-Cal managed care mean to Medi-Cal beneficiaries with disabilities? This issue brief synthesizes recent research about the experiences of non-elderly beneficiaries with disabilities in managed care and fee-for-service delivery systems in California and other states. It is intended to help California policymakers understand and evaluate options for changing the delivery of and payment for services to Medi-Cal beneficiaries with disabilities.

Key Findings Include:

- Limited data are available to determine how people with disabilities fare in Medicaid managed care or fee-for-service programs.

Most states, including California, have done a poor job assessing the quality of care provided to Medicaid beneficiaries with disabilities and holding providers accountable for performance.

- A recent national study using the available data found that, on most measures of access and quality, there was no significant difference between the experiences of Medicaid beneficiaries in managed care and those in fee-for-service.
- In California, managed care enrollees experience fewer preventable hospitalizations than those in fee-for-service; however, beneficiaries with disabilities in both fee-for-service and managed care report difficulty finding physicians, communicating effectively with their providers, and with physical access.
- California's experience with mandatory Medi-Cal managed care provides valuable lessons about the difficulties beneficiaries with disabilities may encounter during a transition period if mandatory managed care is expanded into new counties, and the actions health plans have taken to better serve their members.
- Several options for increasing managed care participation do not rely on mandating enrollment. These options are likely to have a modest impact on managed care enrollment.

Regardless of the path California chooses, the state should take specific actions to improve the

efficiency and effectiveness of the delivery of health services to Medi-Cal beneficiaries with disabilities, including:

- Strengthen state oversight by developing performance standards for providers and health plans that reflect the characteristics and needs of people with disabilities. The performance standards should promote improvements in access, chronic care, and coordination among programs and services.
- Measure and publicly report on the performance of fee-for-service providers and managed care plans.
- Develop reimbursement mechanisms for providers and health plans that will foster investment in efforts to improve the efficiency, quality, and coordination of care provided to high-cost beneficiaries with disabilities.
- Facilitate efforts to improve coordination across the many state programs that serve this population, including medical care services, mental health, rehabilitation, development services, and alcohol and drug programs.

Beneficiaries with Disabilities

Eligibility and Enrollment

According to federal law and Medicaid regulations, an individual is considered disabled if he or she is unable to engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or which has lasted or can be expected to last for a continuous period of 12 months or more. Different definitions apply for children, people who are visually impaired, and people who qualify for Medi-Cal’s working disabled program. To be eligible for Medi-Cal, people with disabilities must also meet the program’s

requirements for income, assets, residence, and citizenship.

Table 1. Types of Disabling Conditions Prevalent Among Medi-Cal Beneficiaries

TYPE	EXAMPLES
Physical	Loss of limb, paralysis, congenital conditions, organ dysfunction
Sensory	Loss of vision, loss of hearing
Developmental	Mental retardation, cerebral palsy, autism, brain injury, epilepsy
Mental	Schizophrenia, bipolar disorder, depression
Other Conditions	HIV/AIDS, cancer, multiple sclerosis

Nearly 94 percent of non-elderly Medi-Cal beneficiaries with disabilities are categorically needy. These individuals automatically qualify for Medi-Cal based on a linkage to a cash assistance program such as the federal Supplemental Security Income (SSI) or California State Supplemental Payment (SSP) programs for the elderly and people with disabilities. People who receive personal assistance through the state’s In-Home Supportive Services program are also categorically eligible, although they may have to pay a share of their health care costs depending on their income. California also has a program that allows low-income workers with disabilities who have too much income to qualify for SSI/SSP to buy-in to Medi-Cal on a sliding scale. The remaining 6 percent of non-elderly, disabled Medi-Cal beneficiaries include those who qualify for Medi-Cal through other eligibility pathways (e.g., Temporary Assistance for Needy Families, or TANF) and the so-called “medically needy” who qualify for coverage because they incur high medical expenses, but who are only eligible each month after they have met their monthly share of cost.

About 40 percent of non-elderly beneficiaries with disabilities become eligible for Medicare after a two-year waiting period.³ For these “dual eligibles,” Medi-Cal pays for Medicare premiums and copayments, as well as wrap-around services that

Medicare doesn't cover, including institutional and community-based long-term care, and prescription drugs. (Prescription drugs will be covered by Medicare beginning on January 1, 2006.)

Beneficiaries with disabilities tend to remain enrolled in Medi-Cal much longer than most other beneficiaries; many are enrolled for a decade or more. This is because Medi-Cal eligibility for many adults with disabilities is tied to disability status determined by the Social Security Administration, which must be expected to last at least one year or until death. In addition, many other Medi-Cal eligible adults with disabilities have low incomes that fluctuate very little. By contrast, enrollment periods for non-disabled adults are often shorter because their eligibility is generally tied to

fluctuating income and they are subjected to more frequent eligibility recertification.

Service Use and Costs

People with physical or mental impairments or other disabling conditions are much more likely to have a chronic illness than other beneficiaries (Figure 1). Moreover, they are nearly five times more likely than other Medi-Cal beneficiaries to have two or more chronic conditions (51 percent and 11 percent, respectively). Consequently, many disabled beneficiaries require more services such as inpatient hospital care, prescription drugs, and long-term care services. People with disabilities may also require services not commonly used by other beneficiaries, such as personal assistance, as well additional support to access services, including transportation to and from appointments, interpreters, longer appointments, and other accommodations.

Because of these differences, the cost of providing health care services for people with disabilities is much greater, on average, than for beneficiaries without disabilities (Figure 2).

Figure 1. Percentage of Medi-Cal Fee-for-Service Beneficiaries with Certain Conditions, 2001

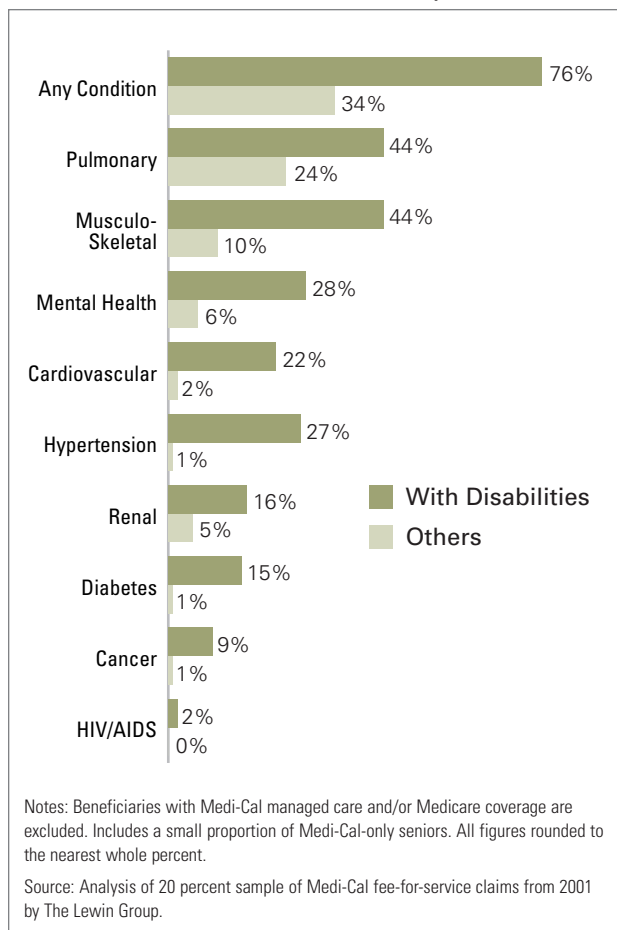
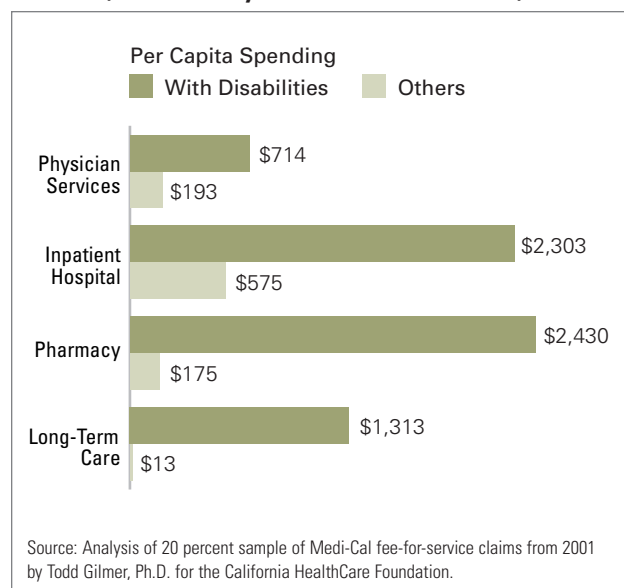


Figure 2. Average Annual Expenditures for Selected Services, Non-Elderly Medi-Cal Beneficiaries, 2001



In 2001, non-elderly Medi-Cal beneficiaries with disabilities comprised about 14 percent of Medi-Cal beneficiaries, but accounted for approximately 42 percent of the program's expenditures.⁴

Delivery System Options

Most — 80 percent — non-elderly beneficiaries with disabilities receive their services through Medi-Cal's fee-for-service delivery system. In the fee-for-service system, beneficiaries may choose any physician who participates in the Medi-Cal fee-for-service program to provide their care. Providers are generally reimbursed by Medi-Cal for each unit of service they provide (e.g., a physician visit or a hospital day). While there are some service limitations and utilization controls, the state has few mechanisms in the fee-for-service environment to control costs other than to reduce provider reimbursement levels.

The remaining 20 percent of non-elderly adult Medi-Cal beneficiaries with disabilities receive their services through Medi-Cal's managed care delivery system. This system includes California's three unique models of managed care, as well as several small, specialized health plans (Table 2). In the managed care system, beneficiaries choose a health plan and select a primary care physician who contracts with the health plan. Health plans restrict members to using providers in their network; however, they are required to provide beneficiaries with a directory of participating physicians and indicate which are accepting new members. The health plan is paid a certain amount each month for each member and agrees to manage a comprehensive set of benefits and assume financial risk for those enrolled. State officials can control costs and maintain budget predictability through the process of setting these health plan capitation rates.

Currently, Medi-Cal managed care is available in 22 of California's 58 counties. In the 14 counties where

managed care enrollment is voluntary for people with disabilities, only a small percentage of those eligible have enrolled in a health plan. In the eight counties served by a County Organized Health System, managed care enrollment is mandatory.

Comparing Fee-for-Service and Managed Care

Although California has had a Medi-Cal fee-for-service system for nearly 40 years and a managed care system for more than 20 years, surprisingly little information exists about how well either system is serving beneficiaries with disabilities. California is not alone: there is a dearth of performance data from other states, and nationally, to determine the quality of care provided to disabled Medicaid beneficiaries.

Several factors contribute to the relative lack of data. First, little attention has been focused on the quality of care provided to this population. Also, collecting consumer satisfaction and other data from people with disabilities can be difficult and expensive. The chief, nationally-recognized tools used to assess quality in managed care are the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans (CAHPS). These tools collect standardized performance measures but do not specifically measure the performance of plans in meeting the needs of people with disabilities, reflecting their origins as tools used by employers to measure the quality of care provided to their employees. In addition, many states and health plans have trouble identifying beneficiaries with disabilities within their data, especially people who are eligible due to reasons other than their disability.

Despite the paucity of data collected by states, recent findings from the National Health Interview Survey and a series of studies in California provide some valuable clues and important lessons about the

Table 2: Distribution of Non-Elderly Adults with Disabilities Among Delivery Systems

DELIVERY SYSTEM	Counties	Total Enrollment	Managed Care Enrollment
<p>County Organized Health Systems</p> <p>Enrollment in managed care is mandatory for almost all beneficiaries, including those with disabilities. Almost all Medi-Cal services are covered by the county plan.</p> <p>Counties negotiate a contract with the California Medical Assistance Commission, an independent state board under the Health and Human Services Agency, and are paid on a capitated basis.</p>	Orange, Monterey, Napa, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo.	94,500	93,600 (99%)
<p>Two-Plan and Geographic Managed Care (GMC)</p> <p>Enrollment in managed care is voluntary for people with disabilities.</p> <p>Most Medi-Cal services are covered by managed care plans but some, such as long term care and mental health, are provided outside of managed care.</p> <p>In Two-Plan counties, health plan options include a Local Initiative plan and a commercial plan.</p> <p>In GMC counties, there are several health plan choices.</p>	<p>Two-Plan: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.</p> <p>GMC: Sacramento and San Diego.</p>	740,000	103,600 (14%)
<p>Fee-for-Service Only</p> <p>There is no managed care option for Medi-Cal beneficiaries in these counties.</p>	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Nevada, Placer, Plumas, San Benito, San Luis Obispo, Shasta, Sierra, Siskiyou, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Ventura, and Yuba.	788,400	None (0%)

Source: Lewin Group analysis of January 2004 Medi-Cal eligibility file.

experiences of disabled beneficiaries with the fee-for-service and managed care delivery systems.

National Health Interview Survey

In June, 2004, researchers at the Urban Institute presented findings of a national study that compared health care access and use among non-elderly adults with disabilities in managed care and fee-for-service delivery systems.⁵ Using the 1997 to 2001 National Health Interview Surveys as the principal data source, the Urban Institute researchers found that health care access and use for disabled Medicaid beneficiaries enrolled in mandatory managed care programs were not significantly different from those in fee-for-service on many measures. On some measures, such as the likelihood of seeing a provider among beneficiaries in urban areas, those enrolled in managed care fared

worse than fee-for-service enrollees. On other measures, such as the likelihood of having a usual source of care among beneficiaries in rural areas, those enrolled in managed care fared better. The authors concluded that states should take caution when mandating managed care enrollment for people with disabilities.

California's Experience

Several recent studies also shed light on California's experience serving disabled beneficiaries in managed care. They include a longitudinal analysis of preventable hospitalization rates from 1994 to 1999;⁶ a series of random-sample surveys (conducted in 1996, 1998 and 2001) of California physicians to assess their participation in Medi-Cal;⁷ a series of 12 focus groups conducted in 2003 with non-elderly, adult disabled beneficiaries throughout California to document and

compare their experiences in the fee-for-service and managed care systems;⁸ a 2003 survey and follow-up interviews with health plan CEOs to understand their perspectives on serving beneficiaries with disabilities;⁹ and an examination by the Legislative Analyst's Office of what the cost impact would be if the Health Plan of San Mateo ceased to operate.¹⁰

Key findings from these studies include:

Beneficiaries in both fee-for-service and managed care face a shortage of Medi-Cal providers. Longitudinal survey data of physicians show that only about one-half of California physicians participate in Medi-Cal, that the physician-to-patient ratio in Medi-Cal is well below national standards, and that participation in Medi-Cal has declined over time.¹¹ Not surprisingly, then, focus group participants with disabilities reported difficulty locating providers willing to accept Medi-Cal, especially specialists, and that when they did find them it was problematic to schedule timely appointments.¹² Those in managed care plans were less likely to report problems finding primary care physicians than those in fee-for-service Medi-Cal, although participants in both managed care and fee-for-service noted difficulty locating specialists. Many focus group participants reported frequent use of hospital emergency rooms as an alternative. Health plan CEOs also reported that it is a challenge to build adequate provider networks because of the limited number of providers willing to participate in Medi-Cal.¹³

Disabled beneficiaries in both delivery systems also experience a variety of access barriers. Focus group participants from both fee-for-service and managed care described the challenges they face obtaining health care services due to their disability.¹⁴ According to most participants, the health care providers they were able to use did not adequately understand their disabilities, and medical technicians and office support staff particularly lacked knowledge of and sensitivity about

people with disabilities. Difficulty with facility access and use of medical equipment was a pervasive issue across all focus groups and was particularly severe for beneficiaries with physical disabilities. Many of these challenges occur at the individual provider level. They are not unique to either delivery system, nor are they unique to Medi-Cal.

Focus group participants reported divergent experiences. There was a striking lack of consistency in quality assessments by participants in different counties, depending on where they received care and the nature of their disability. There was also a great deal of variation reported by members of different health plans within a single county.

Access

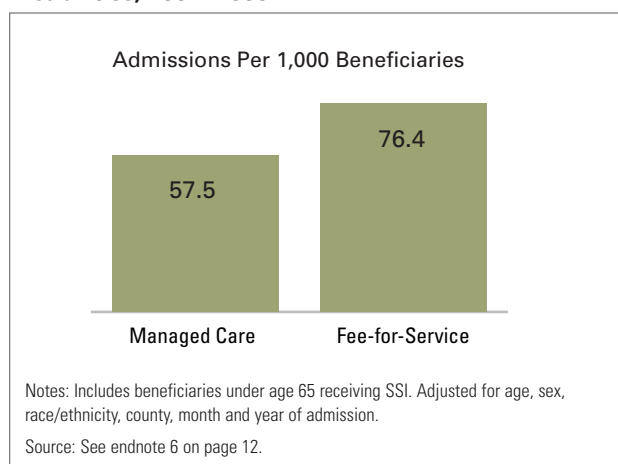
The term "access" refers to the ability of individuals or groups to receive needed services from the health care system in a timely fashion. This may include the availability of a particular service, awareness by individuals that the service exists, how to obtain it, and the ability to get the service in a reasonable amount of time. Health care access for people with disabilities includes an additional level of physical and communication supports necessary for them to benefit from quality health care.

Examples of physical access include getting to, into and through facilities; access to medical equipment such as scales, exam tables, exam chairs and other diagnostic/radiological equipment; and accessible services, i.e., educational, health and wellness programs. Examples of communications access include information delivered in usable formats such as American Sign Language, Braille, large print, electronic, audio formats; use of auxiliary aids and services when needed, such as readers, assistive listening systems, assistance with completing paperwork, and note takers; and, accessible media including web sites, captioned and audio described films and videos.

Medi-Cal Redesign Aging and Disabilities Workgroup Presentation, Brenda Premo and June Isaacson Kailes, April 1, 2004.

Beneficiaries enrolled in managed care experience fewer preventable hospitalizations. Although problems exist in both fee-for-service and managed care Medi-Cal, an analysis of hospital data from 1994 to 1999 found that the number of preventable hospitalizations was significantly lower among health plan enrollees than among comparable groups of fee-for-service enrollees.¹⁵ This comparison of preventable hospitalizations is illustrated in Figure 3. Preventable hospitalizations are those that could have been avoided if beneficiaries' conditions had been well-managed in an outpatient setting, for conditions such as asthma, diabetes, and hypertension. Among beneficiaries with disabilities, the annual preventable hospitalization rate was about one-quarter lower for managed care enrollees than for those in fee-for-service. The authors concluded that compared to fee-for-service beneficiaries, health plan enrollees are more likely to have consistent, better coordinated care because they are required to select a primary care provider as their usual source of care.

Figure 3: Average Annual Preventable Hospitalization Rate Among Non-Elderly Medi-Cal Beneficiaries with Disabilities, 1994–1999



Health plans face challenges serving people with disabilities, but innovative solutions have emerged. Health plans also report multiple challenges to serving beneficiaries with disabilities.¹⁶ In addition to shortages of providers willing to accept Medi-Cal, discussed previously,

health plans are frustrated by the fragmentation of services related to carve-outs. Because carved-out services, such as mental health, are provided by another entity, the health plan cannot ensure communication and coordination among providers. In addition, there may be confidentiality concerns that require withholding information about services being provided, potentially resulting in duplication of services.

Health plans also report that they are using the flexibility that comes with capitated payments to provide specific services and accommodations not available in to fee-for-service enrollees in order to improve access and quality of care for members with disabilities. These include member education and outreach materials tailored to the unique needs of this population, provider directories that rate physical access, and care coordination. Health plans are also able to tailor physician reimbursement arrangements to encourage provider participation and increase the number of providers available to Medicaid beneficiaries. Table 3 on the following page highlights some of the challenges people with disabilities face in obtaining health care services and the actions taken by some health plans to address some of these challenges.

In counties with voluntary managed care enrollment, few beneficiaries have selected a health plan. As shown previously in Table 2, only 14 percent of disabled beneficiaries have voluntarily enrolled in a health plan. Focus groups with disabled beneficiaries indicate that the reasons for this range from a lack of knowledge about managed care options and how to enroll in a health plan, to concerns about restricted provider networks and utilization management techniques common to managed care.¹⁷

Cost savings have been achieved through managed care, but the rate-setting methodology is outdated and data collection needs to be improved. In their analysis of the 2004 to 2005 Budget Bill, the Legislative Analyst's Office (LAO) estimated that the

Table 3. Health Plan Activities to Address Specific Challenges for Medi-Cal Beneficiaries with Disabilities

Challenges	Health Plan Activities
Finding providers willing to accept Medi-Cal	Provide each member with a primary care physician and provide assistance finding specialists. Target physician payment increases to particular specialties or geographic areas with acute access problems. Develop special provider payment arrangements for serving people with disabilities, including higher rate structures or bonuses.
Locating providers equipped to serve people with disabilities	Produce a provider directory that rates basic physical accessibility features of primary care physicians. Offer a consumer call center to assist members in finding accessible providers.
Communicating with providers	Provide information in usable formats such as American Sign Language, Braille, large print, electronic, audio formats; use auxiliary aids and services.
Coordinating care among multiple providers	Provide clinical care coordinators or case managers to help coordinate among providers, serve as the key point of contact for the member, provide personalized assistance, and advocate on behalf of the member to facilitate timely access to care.
Coordinating care for certain complex diseases	Offer disease management programs to help members manage specific conditions, such as diabetes, asthma, or chronic obstructive pulmonary disease (COPD).
Obtaining and maintaining appropriate equipment for special needs	Provide case managers to assess the need for appropriate equipment through routine home visits and assist the member in obtaining these devices. Provide home-based wheelchair repairs for individuals with limited mobility.

Source: *Adults with Disabilities in Medi-Cal Managed Care: Health Plan Practices and Perspectives*. Prepared by the Medi-Cal Policy Institute/California HealthCare Foundation, Oakland, CA, September 2003.

COHS plans are, collectively, saving the Medi-Cal as much as \$300 million annually (\$150 million General Fund).¹⁸ The LAO estimated that the annual cost for beneficiaries with disabilities in a COHS plan was 13 percent less than for those in fee-for-service. The LAO also concluded that the methodology DHS uses to set managed care capitation rates is outdated, and that the state's payment approach may be particularly problematic for COHS plans because they serve large numbers of aged, blind, and disabled Medi-Cal beneficiaries.

In a study completed in September 2003, Mercer Government Human Services Consulting found that most health plans participating in Medi-Cal were profitable and financially stable from 1998 to 2002.¹⁹ In forecasting the financial status of these health plans in 2005, Mercer found that if capitation rate increases continued to lag behind health care inflation, several health plans would be at risk of insolvency. The authors recommended that, in order for state officials to make informed assessments of health plan performance and

set actuarially-sound rates in accordance with federal requirements, Medi-Cal require health plans to provide detailed supplemental financial data for Medi-Cal-specific operations, and take steps to improve the quality of encounter data.

Looking Ahead

As California policymakers consider changes in the ways that managed care is delivered to people with disabilities, there are several key areas that require attention. The following section outlines several enhancements that could improve access to care for people with disabilities in the current fee-for-service and managed care system, followed by a discussion of options for expanding the use of managed care to serve beneficiaries with disabilities. It draws upon California's experience, as well as a careful examination of the experiences of other states that have implemented managed care programs for Medicaid beneficiaries with disabilities, some successfully, others not.²⁰

Strengthening the Current System

California should take the following steps to strengthen programs for beneficiaries:

Strengthen state oversight by developing performance standards and measures for health plans and providers serving people with disabilities. Program officials should develop performance standards that better reflect the characteristics and needs of people with disabilities, and measure the performance of fee-for-service providers and managed care plans. These actions would help program officials to ensure accountability and promote improvements in access, chronic disease care, and coordination across programs and services. It would facilitate apples-to-apples comparisons between the fee-for-service and managed care delivery systems and among participating health plans, and inform policy discussions about the shape of Medi-Cal in years to come. This system can build on existing measures (e.g., by collecting and analyzing HEDIS and CAHPS separately for disabled beneficiaries), but should also include specialized utilization measures related to this population. States can also build upon the external quality review organization (EQRO) process to developed focused clinical quality review studies for enrollees with disabilities. In addition, state lawmakers must ensure that sufficient resources are available to support ongoing oversight and quality improvement.

Increase physical and communication access.

Program officials, health plans, and health care providers should make efforts to increase the availability of accessible services for people with disabilities. For example, providers and health plans could ensure that care sites are accessible (e.g., have equipment such as height-adjustable exam tables and other diagnostic/radiological equipment), and work with the state to ensure the availability of sign language interpreters, when needed, and other auxiliary aids and services, such as explanation of benefits and consent forms in

alternative formats (Braille, large print, disks, audio formats), and accessible media including Web sites to assist beneficiaries with disabilities in accessing services.

Develop appropriate reimbursement mechanisms for managed care plans that reflect the cost of serving beneficiaries with disabilities. Medi-Cal uses only two capitation rates for beneficiaries with disabilities residing in the community: one rate for people diagnosed with HIV/AIDS, and one rate for all others. The state could adopt additional diagnosis-specific risk adjustment mechanisms to ensure that health plans are paid adequately for high-cost individuals. A risk adjustment system would have two benefits. First, it would help the state more accurately compensate health plans, particularly in counties where beneficiaries with disabilities have a choice of delivery systems and health plans. Second, it would encourage health plans to invest in programs and services aimed at meeting the needs of high-cost beneficiaries with disabilities. Currently, health plans that develop such programs run the risk of adverse selection; that is, they could attract a large share of beneficiaries with disabilities who have higher than average health care utilization and costs. The state should also update health plan capitation payments regularly to reflect changes in health care costs, which have been growing at a much faster rate for beneficiaries with disabilities than for other Medicaid and commercial populations. As part of any effort to improve the rate-setting process for managed care and ensure that state funds are spent wisely, the state should improve its encounter data collection systems and collect Medi-Cal-specific financial data from participating plans.

Facilitate efforts to improve coordination across the many state programs which serve this population.

In addition to the medical care services covered by Medi-Cal, many people with disabilities receive services through other state programs. These services

include mental health, rehabilitation, employment, housing, development services, personal care, and alcohol and drug programs. The fragmentation of care for this population into different programs and across agencies creates incentives for cost shifting and enormous challenges for consumers and families. Greater attention should be paid to coordinating efforts and sharing information across programs, and to helping consumers navigate the complex maze of programs and rules.

Increasing Enrollment in Managed Care

The Legislature has already decided to expand enrollment in Medi-Cal managed care among people with disabilities in two ways. First, it has approved a geographic expansion of voluntary managed care in six counties. Second, it has approved expansion of the COHS model—which includes mandatory enrollment for most Medi-Cal beneficiaries who aren't dual eligible, including people with disabilities—in seven counties. Should California policymakers decide to further increase enrollment of disabled beneficiaries in managed care, they have several options. These options will have different ramifications for consumer choice, access to care, managed care enrollment, and program expenditures and savings (e.g., a mandatory program may have a greater effect on program expenditures but offer fewer choices for consumers).

Enhance outreach efforts in counties where managed care enrollment is voluntary. Focus groups have shown that a key reason why more disabled beneficiaries have not voluntarily selected a health plan is that few are aware of Medi-Cal managed care and their option to participate. Because enrollment in Medi-Cal is automatic for many disabled beneficiaries due to their eligibility for SSI, few come in contact with county workers who could explain their delivery system options. Disabled beneficiaries are defaulted to fee-for-service unless they actively choose a health plan,

and must go out of their way to learn about their options for enrolling in a health plan. State and county officials, health plans, and consumer advocates can work together to increase awareness and understanding among beneficiaries with disabilities of managed care as an option for them. Such efforts should address consumer concerns that managed care plans restricts choice of providers and that they have a financial incentive to deter use of necessary care. Efforts to educate consumers should also include comparative performance information on the fee-for-service system and health plan choices in each county, as well as information about how to navigate the managed care environment. According to focus group participants, this information would also be helpful to many existing managed care enrollees.

Eliminate managed care enrollment barriers. In some respects, the managed care and fee-for-service programs do not compete on even playing fields. First, some aspects of the Medi-Cal eligibility and health plan enrollment process may make it difficult for beneficiaries with disabilities to enroll or stay enrolled in a health plan in counties with voluntary enrollment (Two-Plan Model or Geographic Managed Care). For example, if a disabled TANF beneficiary in one of these counties is enrolled in a health plan and becomes eligible for SSI, he or she will be disenrolled from the health plan when the aid code changes. The state could modify the enrollment process to allow beneficiaries enrolled in a Medi-Cal health plan to remain in the same health plan if their aid code changes. California could also obtain a waiver to allow enrollees in the new California Working Disabled buy-in program to enroll in health plans if one is available in their county. Second, while cost growth in managed care is controlled by limiting annual increases in capitation payment rates, equivalent constraints are not placed on the fee-for-service system. This makes it difficult for plans to invest in services to better serve members with

disabilities, even when doing so would be better for the state budget and for beneficiaries.

Provide incentives for beneficiaries to choose managed care. As part of his Medi-Cal redesign plan, the governor proposed a requirement that some beneficiaries pay premiums or cost-sharing. If this proposal were adopted, state officials could pass on a portion of projected savings associated with managed care to beneficiaries in the form of lower premiums or cost-sharing to encourage voluntary enrollment.

Switch from an “opt-in” to an “opt-out” approach. California could implement an “opt-out” voluntary enrollment policy, such as the one used in Wisconsin, in which new beneficiaries are automatically assigned to a health plan unless they elect to remain in fee-for-service. This approach would need appropriate safeguards for beneficiaries with cognitive impairments and others who are unable to properly evaluate their options.

Mandate enrollment in managed care. Voluntary enrollment approaches have had limited success achieving high rates of participation in managed care. Ten years of experience with County Organized Health Systems in California shows that mandatory enrollment for people with disabilities can work. But numerous problems in the early years of this experience provide valuable lessons. For example, many beneficiaries had difficulty understanding the enrollment materials and navigating the managed care system, and did not understand their choices or rights. Should mandatory enrollment be expanded, two issues are critical. First, meaningful, informed consumer choice is essential, especially for beneficiaries with disabilities. Second, ensuring continuity of care must be a high priority during enrollment, particularly for individuals with complex conditions who have established successful relationships with primary care and specialty care providers through years of trial and

error. It takes time to for health plans to build provider networks in new areas to meet the broad array of services used by people with disabilities. Moreover, some experts have noted that building a competent and accessible provider network is an art, not a science, as there is no board certification in treating people with disabilities.

Conclusion

The governor has proposed tripling the number of Medi-Cal beneficiaries with disabilities enrolled in managed care. Whether or not mandatory managed care is expanded for people with disabilities, the state should invest some portion of the savings it achieves through managed care in establishing better performance standards and monitoring systems to increase public accountability, provide apples-to-apples comparisons of the managed care and fee-for-service systems, and promote improvements in access, chronic care, and coordination across programs and services.

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ENDNOTES

1. California HealthCare Foundation estimates using January 2005 Medi-Cal enrollment data as of August 4, 2005 (www.dhs.ca.gov/mcss/RequestedData/Special_Family/spec_fam.htm).
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