

How Health Plans Identify and Serve Medicaid Special Needs Populations



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INTRODUCTION

This report presents the results of a study conducted in the winter and spring of 2000 of managed care organizations that enroll Medicaid recipients with special needs. The purpose of this study was to obtain baseline information about how health plans identify and serve their Medicaid special needs populations. This baseline information might be used to identify areas for quality improvement or innovations that might be more broadly adopted as enrollment of special needs members continues to grow.

The term “special needs populations” is very broad and encompasses numerous groups, including low-income children and high-risk pregnant women, as well as people with serious mental illness, physical disabilities, or developmental disabilities. It includes people who have the more common chronic illnesses, such as asthma and diabetes, as well as individuals with less common but very serious illnesses, such as AIDS and cystic fibrosis. We were particularly interested in knowing how plans that enroll this entire range of individuals with special needs identify these populations and how they address health care needs that are chronic.

The enrollment of Medicaid recipients in managed care has grown at a fast pace, more than tripling in the five-year period from 1993 to 1998.¹ With this expansion, increasing numbers of individuals with disabilities and chronic illnesses have been enrolled in managed care plans. Although the Medicaid TANF population, consisting primarily of low-income women and children, includes individuals with disabilities and chronic illnesses, the majority of Medicaid recipients with disabilities receive Medicaid benefits as a result of qualifying for SSI. From 1995 to 1999, the number of states enrolling Medicaid SSI recipients in managed care increased from 21 to 32 (Landon, Tobias, Epstein, 1998, and Landon et al, unpublished data).

The influx of low-income chronically ill and disabled individuals into Medicaid managed care gives rise to numerous public policy, clinical, and programmatic issues. The public policy issues are being debated and addressed by federal and state agencies, as well as researchers and academics.² At the heart of these discussions are contracting standards, performance monitoring, data tracking, and financing. The clinical and programmatic questions, on the other hand, have received very little public attention. Some of the questions raised by the enrollment of a broad range of special needs populations in Medicaid managed care include:

¹ Medicaid managed care enrollment grew from nearly 5 million people in 1993 (14 percent of the Medicaid population) to 54 percent of the Medicaid population in 1998 (HCFA web site, www.hcfa.gov/medicaid/trends98.htm, “National Summary of Medicaid Managed Care Programs and Enrollment, 1998).

² Including at the federal level by the Health Care Financing Administration, Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, National Institute on Disability and Rehabilitation Research, Assistant Secretary for Planning and Evaluation, and Administration on Developmental Disability; at the state level by Medicaid programs, Substance Abuse Authorities, and Departments of Public Health, Mental Health, and Developmental Disabilities; and by numerous public policy and research institutions.

- Do the health plans still focus their efforts on low-income women and children, or have they expanded their attention to encompass individuals with more serious disabilities and chronic illness?
- Do health plans single out particular diagnoses for programmatic interventions, or do they focus on high-cost populations, regardless of diagnosis? The management of specific diagnoses – asthma, diabetes, hypertension, and cardiovascular disease – is the bread and butter of the disease management industry and the focus of much research. High-cost or intensive case management programs have been part of the managed care menu of health plan interventions for over a decade.
- To what extent have health plans developed more broad-based programs for individuals that have multiple diagnoses, including disability or chronic illness, mental health, substance abuse, and/or social and long-term support issues?
- Are the programs that health plans have developed mainly clinical in nature, relying upon nurses and physicians, or do they include social and support services?
- Do health plans “manage” special needs populations internally, or do they have special relationships with network providers to share in the management of these populations?

To better understand the state of the art in serving Medicaid special needs populations it is also important to know where these members fit in the overall health plan membership and how the plan is set up to conduct basic operations. We asked health plans to respond to questions in eight major areas, including:

- Background information about the plan, its size, its membership composition, and the length of time the plan had served Medicaid and SSI enrollees;
- Enrollment information;
- The health risk assessment process;
- Special clinical programs for enrollees, including disease management programs, intensive or high-cost case management programs, and other case management programs;
- Behavioral health programs;
- Benefit exceptions;
- Quality improvement; and
- The plan’s interest in participating in follow-up activities.

METHODS

Surveys were mailed to the Medicaid director or chief executive officer of 141 health plans in 23 states that enroll the SSI disabled population in capitated managed care programs. We excluded plans in states that were dismantling their capitated programs for the SSI population, had a single small program, or ran a program that was less than one year old. Fourteen plans were subsequently dropped from the sample because they had gone out of business, merged with another health plan, or cancelled their Medicaid contracts. Thus, the final sample size was 127 managed care plans.

A reminder postcard was mailed out, and a minimum of four follow-up telephone calls were made to solicit responses from plans that did not respond to the initial request. Plans responded by mail, fax, e-mail, and in a few cases, by telephone. Sixty-one managed care plans responded to the survey, for a response rate of 48 percent. Responses were received from plans in 20 of the 23 states included in the study. Responses were entered into an ACCESS database and then transferred to EpiInfo for analysis.

RESULTS

Background Information

We collected background information on all respondents in order to identify the type and size of each plan and verify that the plan enrolled the SSI population. Thirty-eight percent of the plans had a mix of commercial and Medicaid members. The remaining 62 percent reported a membership that was predominantly Medicaid recipients. The plans ranged in size from several hundred members to over 100,000 members, with a fairly even distribution over this range.

The enrollment of the SSI population in these plans ranged from less than 500 to over 10,000. Again, the responses were distributed evenly along this continuum. Overall, the SSI enrollment constituted approximately 10 percent of each plan's Medicaid enrollment. Interestingly, 26 percent of the plans could not estimate the numbers of SSI disabled enrollees in their plan.

Enrollment Information

In order to enroll members with special needs into clinical programs, health plans first need to identify individuals who might benefit from the programs. Several studies have documented difficulties encountered by enrollment counselors in contacting Medicaid recipients for the purposes of selecting a health plan (Kenesson), and the inability of states to provide accurate information to health plans about new members (Regenstein, Rosenbach).

Confirming the findings of studies conducted of state Medicaid programs and their enrollment counselors, 95 percent of the plans reported that they received address information on new enrollees, but only half of them received telephone numbers. Other information that might assist plans in contacting new enrollees, such as the primary language of the new member, or the member's primary care provider, was only received by 40 percent and 25 percent of the health plans, respectively.

The majority of plans (89 percent) reported that they received auto-assignments from an enrollment broker or the state. Auto-assignment occurs in states with mandatory Medicaid managed care programs if the Medicaid member does not respond to a mailing or other outreach efforts to select a managed care plan (Kenesson). Several plans commented that it is much more difficult to contact auto-assigned enrollees than enrollees who voluntarily make a health plan selection because the information available on auto-assigned members is less likely to include a correct address, telephone number, and primary care provider.

Outreach Efforts

Plans varied widely in the percentage of new members they were able to reach through outreach efforts after enrollment. They were able to reach from 10 percent to 100 percent of their new enrollees through mail, telephone, and in-person outreach efforts. The responses were distributed all along this continuum. Approximately one-third of the plans were unable to estimate their contact rates. We asked how outreach was done for the purpose of conducting the health risk assessment. One-third of the plans reported using mail only, while the other two-thirds used a combination of activities that included telephone outreach or in-person contacts.

We asked if plans used any incentives to encourage enrollees to respond to outreach efforts. Eighteen percent of the plans (11) responded that they used a range of incentives from gift certificates to health products to encouraging a response. One plan offered a graduated set of incentives, with the largest value gift going to those who responded most quickly. Another plan entered the names of all respondents into a quarterly drawing for a color television set. This plan said they conducted all initial risk assessments by mail, and the incentives vastly improved the response rate. Finally, several plans noted that they once had incentive programs, but that these programs had been discontinued because of lack of success.

Health Risk Assessment

A health risk assessment, especially for new enrollees, is one strategy for identifying members who might benefit from special clinical programs. A recent study of Medicaid managed care found that only one-third of the states required plans to conduct a health risk assessment within a specified timeframe (Regenstein). However, in our study two-thirds of the plans reported that a health risk assessment was conducted on new enrollees within 90 days of enrollment.

Different models of health risk assessment were identified, including the performance of the assessment by state or county staff or an enrollment counselor prior to health plan enrollment, by the plan itself, or by the member's primary care provider. Only 12 percent of the plans received health information at the time of enrollment. Half of the plans (32) reported that they conducted the risk assessments themselves. Commercial plans were slightly more likely to conduct a health risk assessment than Medicaid plans.

Half of the plans that conducted a health risk assessment used a nurse or combination of nurses and other staff to conduct the assessment. One-third of the plans used member services staff, social workers, and other health plan staff to conduct the assessment. A small number of plans conducted the health risk assessments by mail and did not report any in-person contact with the new enrollee.

When asked what happens to the information if someone appears to have a health risk, plans most commonly responded that this information was forwarded to a case management or disease management program for additional follow-up with the member. One-quarter of the plans specifically mentioned that they also contacted the enrollee's primary care provider. A small number of plans mentioned that they developed an Individual Care Plan for the enrollee. A few plans said that nothing was done because their case management programs were overwhelmed

Special Clinical Programs

Health plans and provider organizations operate many different kinds of clinical programs, such as disease management, intensive or high-cost case management, and other care coordination programs. There are no standard definitions for many of these programs (Rosenbach), and the boundaries between them are sometimes blurred. For conceptual purposes, we developed three broad program categories: disease management, intensive or high-cost case management, and other broad-based case management programs. We allowed health plans to define and categorize their programs themselves.

The large majority of health plans reported programs in all three categories. Eighty-five percent of the plans reported having one or more disease management programs, 74 percent reported an intensive or high-cost case management program, and 80 percent reported other case management programs.

The most common categories of disease management programs included:

- Asthma 61%
- Diabetes 52%
- CHF/Cardiovascular 30%
- Pregnancy 26%
- Hypertension 11%
- Sickle cell 8%
- HIV/AIDS 8%

Most of the intensive case management programs focused on any high-cost high utilizers regardless of diagnoses. However, 10 percent of the plans reported a special program for infants in neonatal intensive care (NICU), and another 10 percent reported a special program for high-risk pregnancies.

The most common categories of population-specific case management programs included:

- Pregnancy/high risk pregnancy 44%
- Children with special health care needs 25%
- HIV/AIDS 23%
- Physical disability/rehab/users of durable medical equipment 16%
- Transplants 16%
- Developmental disability 8%

Other populations mentioned by at least one health plan included dual eligibles (Medicaid and Medicare), frail elders, traumatic brain injury, foster children, and people with serious mental illness.

Behavioral Health

Although plans were free to include behavioral health programs under the category of special clinical programs, we added a separate section on behavioral health. Because many states carve this benefit out of their managed care programs for medical care, the health plan has little control over these services. In addition, we wanted to know how many health plans carve out the benefit to behavioral health organizations, how many manage the benefit directly, and if there were differences in their responses based on the management model.

Among our survey respondents slightly less than half (49 percent) reported that behavioral health services were included in their Medicaid managed care contracts. Of this group, over half (59 percent) carve the benefits out to a behavioral health organization, while the remainder (41 percent) manage the benefits themselves.

We asked if there was any special programming to coordinate behavioral health and physical health services. Of those plans that covered behavioral health services under their Medicaid contract, 55 percent responded affirmatively. This response was evenly divided among those plans that managed the benefit internally and those that carved it out to another organization.

Finally, we asked plans to provide a brief description of any special behavioral health programs for a range of special needs populations. Seventeen percent of the plans provided a description of a program operated by the plan or its behavioral health subcontractor. These special behavioral health programs were designed for people with serious and persistent mental illness, children with serious emotional disturbances, people with developmental disabilities, and/or people with physical disabilities.

Benefit Exceptions

A subset of individuals who receive Medicaid SSI benefits incur very high medical costs on an ongoing basis, including some individuals with HIV or spinal cord or traumatic brain injuries, children with multiple congenital anomalies or sickle cell anemia, and people with cystic fibrosis. Others have needs for certain benefits, such as durable medical equipment, home health, or mental health, that far exceed the level of benefits needed by most TANF or commercial enrollees. Therefore, we were interested in knowing how health plans that enroll the Medicaid SSI population handle exceptions to benefits that might be requested more frequently for these enrollees.

Sixty-nine percent of plans reported having a formal or informal system for authorizing exceptions to benefits. These plans reported that most of the time benefit exception requests were authorized. The three most commonly requested exceptions cited by the plans included pharmaceuticals that were not part of the formulary (17 percent), durable medical equipment (14 percent), and out-of-network referrals (12 percent). Other benefit exceptions included home care, supplies, cosmetic procedures, herbal medications, habilitation therapy, home modifications, therapy camps, and respite care.

Quality Improvement

We asked health plans if they had any initiatives aimed specifically at improving the quality of care for enrollees with disabilities. Twenty-one percent of the plans (13) reported that they had implemented such initiatives. These included two dental programs for members with mental retardation or developmental disabilities, three care coordination programs, and two disability-specific patient satisfaction studies. Other disability-specific activities included improvements in the performance of screening enrollees with other disabilities for depression, developing programs for enrollees with serious mental illness, and implementing HIV-specific measures. Other quality improvement activities included standard quality management initiatives, such as mammograms, flu shots, EPSDT screenings, and diabetes care, that focused on performance related to the receipt of these services by a specific enrollee population with disabilities.

Thirty percent of the plans reported that they were planning to implement new quality improvement initiatives for enrollees with disabilities in the future. Some of the areas mentioned by the plans included initiatives related to HIV care, expansion of initiatives that currently focus on children with special health care needs or adults with disabilities, and evaluation and improvement of current care management activities.

DISCUSSION

About half of the plans responded to the survey. We can surmise from this response rate that the other fifty percent of health plans were too busy to respond or had few activities that address the needs of this population. If the second scenario is true, the results of this

report give an overly optimistic picture of health plan activities. However, the information obtained from the study is useful in identifying innovative or best practices.

The health plans had very little information on newly enrolled members other than member name and address. Telephone numbers are provided only fifty percent of the time, and often these telephone numbers are no longer valid. This makes it difficult for health plans to conduct outreach or contact new members for the purposes of health risk assessment. At the same time, state agencies often have a wealth of information about their program participants, and this information could be very useful to health plans both in outreaching to new members and in identifying individuals who may have special needs. However, there are few examples of how to retrieve this information and communicate it in a meaningful manner to plans.

Almost all plans received information regarding newly enrolled members' category of assistance, yet over one-quarter of the plans could not provide information about the number of SSI enrollees in the plan. When a plan cannot even estimate its SSI enrollment this is a fairly strong indication that there is no focus on members with special needs, unless perhaps those needs result in extraordinarily high costs.

The use of some form of health risk assessment was fairly common among the health plans. However, who performed the assessment, the contents of the assessment tool, and the extent of follow-up varied a great deal among the plans. In some plans only specific conditions were targeted for case management. Health risk assessment is an area for considerable investment and dissemination of successful strategies.

Health plans have implemented a very wide variety of clinical programs for their Medicaid members. Disease management programs are becoming more common in commercial plans and constitute a large number of the Medicaid managed care initiatives. Many health plans also provide high-cost/intensive case management programs. These programs were also developed originally for a commercial membership, but have applicability to Medicaid enrollees as well. Finally a large percentage of plans have other general case management programs that adopt a more public health approach to care coordination and management.

The population focus of these special clinical programs is still predominantly maternal and child health. However, there are significant examples of other population focuses, including adults with disabilities, children with special health care needs, HIV/AIDS, sickle cell anemia, and developmental disabilities. Behavioral health programming is a complicated area to analyze because so many states have carve-outs for this service, and carve-outs make it difficult for the health plans to coordinate care. At the same time, many people with physical and development disabilities and chronic illness have serious behavioral health needs. There were very few specialized behavioral health programs considering that an estimated 30 percent of the population needs these services.

The wide range of responses about benefit exceptions was particularly interesting. What one plan considers a routine exception may not appear at all on a second plan's list of

exceptions. While one-third of plans had no benefit exceptions, the other two-thirds of plans had multiple exceptions. The organizational culture of plans clearly plays a role in how health plans view their opportunities for providing services for enrollees with special needs and how they tailor their benefits to individual needs.

CONCLUSION

The baseline information about how Medicaid managed care plans identify and serve their Medicaid special needs populations reveals, for the most part, that the plans are at the beginning of a learning curve around strategies that address these special needs. Outreach to and identification of special needs members is usually identical to the plan's outreach and identification strategies for all Medicaid enrollees. A few plans administer a second level screening for more high risk enrollees, but most still struggle with the basic functions of new enrollee contacts. Some plans have been successful with multiple outreach approaches, while others have reported success with incentives to respond to outreach efforts. At the same time, few plans have outreach strategies that are clearly tailored to address special needs members, other than high-risk pregnant women, newborns, or enrollees with asthma.

Despite the difficulties of outreach and identification, most of the plans have adopted and adapted commercial managed care program strategies for their Medicaid special needs populations, including disease management programs and high cost or intensive case management programs. Most of the plans continue to focus their efforts on high-risk pregnancy, well child care, and the most common chronic diseases such as asthma, diabetes, and hypertension. However, a sizeable minority of health plans has initiated disease management programs for less common chronic diseases, as well as case management programs for enrollees with serious chronic illness or disability. In addition, the majority of health plans also have provisions to make exceptions to benefits for members with special needs. Finally, some health plans have devoted significant efforts to coordination of physical and behavioral health services for their members with special needs.

These latter activities suggest that there are areas of innovation in serving special needs members that could serve as models for improvement for other plans. In addition, it is likely that these more innovative health plans could learn much from each other through the sharing of information, policies, and program strategies.

REFERENCES

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ATTACHMENT

State Locations of Plans that Responded

Arizona	2	Massachusetts	2	Oregon	6
California	8	Maryland	3	Pennsylvania	3
Colorado	2	Michigan	6	Tennessee	3
Wash. DC	1	Missouri	3	Texas	1
Delaware	1	Nebraska	2	Utah	5
Florida	3	New Mexico	2	Wisconsin	3
Kentucky	1	New York	4		