

# New York's SSI Medicaid Beneficiaries: The Move to Managed Care

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The Medicaid Institute at United Hospital Fund provides information and analysis explaining New York's Medicaid program, with the goal of helping all stakeholders redesign, restructure, and rebuild the program.

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Medicaid managed care enrollment—over 2.5 million people statewide, including 1.9 million in New York City—accounts for 60 percent of all Medicaid beneficiaries in New York.<sup>1</sup> After some 15 years of demonstration programs, voluntary enrollment policies, and, ultimately, mandatory enrollment in most parts of the State, three out of four non-elderly, non-disabled Medicaid beneficiaries are now enrolled in managed care.

Until this year, the State did not require any disabled or elderly beneficiaries—often referred to as Supplemental Security Income (SSI) Medicaid beneficiaries (see “FAQs,” page 3)—to enroll in Medicaid managed care, and relatively few had done so voluntarily. But a new policy is changing that: some 125,000 SSI beneficiaries in New York City now must choose, or be assigned to, a managed care plan.

<sup>1</sup> Medicaid enrollment includes Family Health Plus (FHP) but does not include some 350,000 enrollees in Child Health Plus B (CHP B), New York's SCHIP program.

A review of these enrollees' characteristics and experiences under fee-for-service Medicaid documents several relevant patterns: costs for this population vary considerably; coverage is generally stable; chronic diseases and behavioral health conditions are prevalent; and rates of avoidable hospital stays are low. Perhaps most significant is that, under current patterns of service use, a large share of Medicaid spending on these beneficiaries will remain on a fee-for-service basis even after their enrollment in Medicaid managed care, because the State's managed care benefits package "carves out" or excludes a number of key service areas.

### **Spending and Coverage Patterns**

Annual per capita Medicaid spending on New York City's SSI beneficiaries who face mandatory enrollment in Medicaid managed care averages \$10,269.<sup>2</sup> This is about 60 percent lower than per capita spending on all SSI beneficiaries, which averages about \$25,000, because many of the most costly beneficiaries remain exempt or excluded from managed care. Yet it is considerably higher than Medicaid spending for non-elderly beneficiaries without disabilities, which averages less than \$4,000 per adult and less than \$2,000 per child.

Average spending levels can hide important patterns, however. Dividing the approximately 125,000 SSI beneficiaries facing mandatory Medicaid managed care in two ways offers a more informative profile. First, this analysis separates enrollees into three age groups: adults (18-64), who account for 64 percent of these SSI beneficiaries; children (0-17), who account for 23 percent; and the elderly (65 and over), who account for the remaining 13 percent. Second, we separate enrollees into three cost categories: the 80 percent accounting for the lowest per capita spending (low-cost), the 15 percent in the next spending bracket (high-cost), and the costliest 5 percent (ultra-high-cost). Because adults represent by far the largest age group of SSI beneficiaries facing the mandate, this discussion focuses primarily on them, but highlights some key differences among children and the elderly.

<sup>2</sup> All Medicaid spending estimates in this analysis reflect 2004 data. These estimates are not adjusted to reflect changes in the prices or utilization of Medicaid services.

# FAQs:

## SSI Beneficiaries and the New Medicaid Managed Care Mandate

### Who are New York’s SSI Medicaid beneficiaries?

New York State’s Medicaid eligibility requirements for the disabled and elderly are pegged to the federal Supplemental Security Income (SSI) program, which provides cash assistance to disabled or elderly persons who meet the required financial and functional criteria. As a result, disabled and elderly Medicaid enrollees in New York are often referred to as SSI Medicaid beneficiaries. These individuals are members of families with low incomes—under \$8,305 for one-person families, or under \$10,800 for two-person families—and less than \$6,000 in assets. They are either elderly or have a long-term disability—including blindness and a range of circulatory, respiratory, and musculoskeletal conditions, mental illnesses, and/or developmental disabilities—preventing adults from engaging in substantial gainful activity or causing marked and severe functional limitations among children.

### Which SSI beneficiaries does the new mandate cover?

The current Medicaid managed care mandate applies to about 125,000 SSI Medicaid beneficiaries, all of whom live in New York City, are currently in fee-for-service Medicaid, and do not satisfy any Medicaid managed care exemptions or exclusions. Beneficiaries with exemptions—including those with HIV/AIDS or a “serious and persistent mental illness”—may enroll in Medicaid managed care voluntarily. Beneficiaries with exclusions—including dual Medicare-Medicaid enrollees, residents in nursing homes or psychiatric facilities, and individuals who become eligible for Medicaid only after spending down a portion of their income—are barred from enrolling in Medicaid managed care. (Because the vast majority of elderly Medicaid beneficiaries have Medicare coverage, less than 5 percent face the current mandate.)

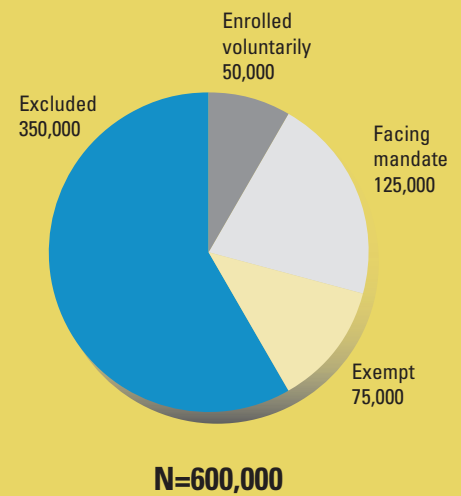
Among approximately 600,000 SSI beneficiaries in New York City:

- 50,000 have enrolled in Medicaid managed care voluntarily;
- 125,000 face the current mandate;
- 75,000 are exempt from the mandate, but may voluntarily enroll;
- 350,000 are excluded from Medicaid managed care.

### Will other SSI beneficiaries face mandatory Medicaid managed care in the near future?

The State may expand the mandate to include additional groups of SSI beneficiaries, both within and beyond New York City, subject to the terms and conditions of New York’s Federal-State Health Reform Partnership (F-SHRP) Medicaid Waiver.

SSI Medicaid enrollees in New York City



The differences in Medicaid spending per SSI beneficiary within the group facing the mandate are striking. High-cost adults average \$24,643 in annual per capita costs and ultra-high-cost enrollees average \$88,277—more than 20 times the \$3,810 in spending on their low-cost counterparts (Table 1). Variation by cost category among children and the elderly is similar, illustrating that a minority of the SSI beneficiaries facing mandatory Medicaid managed care have health care needs that drive substantial Medicaid spending. On the other hand, spending for the 80 percent of SSI adults classified as low-cost is on par with average spending on all non-disabled adults (\$3,691)—illustrating that most SSI beneficiaries facing the current mandate account for levels of Medicaid spending that are similar to those for non-SSI beneficiaries.

SSI beneficiaries facing the mandate appear to have stable coverage patterns. Between 85 and 95 percent of adults and children in all cost categories have a full calendar year of Medicaid coverage. By contrast, only 48 percent of Medicaid’s non-SSI adults and 59 percent of non-SSI children have Medicaid for the full year. (Because of the higher death rates in their age group, elderly enrollees are less likely to complete a full year of Medicaid coverage.) Adult and child SSI beneficiaries facing the mandate average more than 11 months of Medicaid coverage each year—significantly more than non-SSI adults (9.2 months) and non-SSI children (9.8 months). These findings indicate that retention—a persistent challenge for a significant share of Medicaid enrollees—is not a major problem for SSI beneficiaries facing the mandate. Disabled or elderly individuals who satisfy Medicaid’s income and asset limits typically stay eligible for coverage—mainly because they are unlikely to reenter the workforce—and they generally remain enrolled.

**Table 1**  
**Spending and Coverage**

	Children (0-17)			Adults (18-64)			Elderly (65+)		
	Low	High	Ultra-high	Low	High	Ultra-high	Low	High	Ultra-high
Annual per capita cost	\$2,616	\$17,203	\$83,933	\$3,810	\$24,643	\$88,277	\$2,176	\$19,305	\$73,799
Share with full year of coverage	86%	95%	91%	91%	92%	87%	68%	77%	78%
Months (out of 12) covered	11.2	11.8	11.6	11.5	11.6	11.3	9.9	10.6	10.5
Group as share of SSIs facing mandate	19%	3%	1%	51%	10%	3%	10%	2%	1%

## Diagnostic Profile

The prevalence of key diagnoses among SSI enrollees facing the mandate varies considerably. Most low-cost adults are not diagnosed with a chronic health problem—defined as a medical, rather than mental health or substance abuse, condition—that is continuous or persistent over an extended period of time. By contrast, more than three-quarters of high-cost and ultra-high-cost adults have at least one chronic condition, and most have two or more (Table 2). Among the elderly, more than two-thirds of ultra-high-cost enrollees have two or more chronic conditions. Children have much lower rates of chronic conditions.

**Table 2**  
**Diagnoses**

	Children (0-17)			Adults (18-64)			Elderly (65+)		
	Low	High	Ultra-high	Low	High	Ultra-high	Low	High	Ultra-high
<b>Prevalence of any chronic conditions</b>									
None	78%	63%	60%	53%	22%	24%	55%	14%	8%
One	21%	32%	32%	26%	26%	19%	29%	33%	21%
Two or more	1%	5%	8%	21%	52%	57%	17%	53%	71%
<b>Prevalence of common chronic conditions</b>									
Asthma	20%	31%	30%	14%	27%	24%	3%	10%	12%
Diabetes	0%	2%	2%	15%	35%	38%	14%	37%	44%
Cardiovascular condition	1%	3%	8%	33%	63%	62%	39%	79%	86%
<b>Prevalence of behavioral health conditions</b>									
Mental health only	30%	62%	60%	22%	27%	24%	5%	19%	28%
Mental health and substance abuse	0%	1%	1%	6%	17%	16%	0%	2%	4%
Substance abuse only	0%	0%	0%	7%	14%	13%	1%	6%	7%
Neither	70%	37%	39%	66%	42%	46%	93%	73%	60%

Among adult SSI enrollees, the incidence of key chronic conditions in both the high-cost and ultra-high-cost categories is striking. About one-quarter have asthma; more than a third have diabetes; and nearly two-thirds have a cardiovascular condition, defined here as coronary heart disease, congestive heart failure, or hypertension. Among elderly SSI enrollees in the high-cost and ultra-high-cost categories, the incidence of asthma is lower but rates of diabetes and cardiovascular conditions are higher than for non-elderly adults. The prevalence of key chronic conditions indicates that the more costly SSI enrollees facing the mandate—particularly among the adult and elderly age groups—pose significant challenges for the health plans enrolling them and the providers treating them.

Despite the mandate's current exclusion of individuals with serious and persistent mental illness, the prevalence of behavioral health conditions—less severe mental health conditions and substance abuse issues—among SSI enrollees facing the mandate is significant. A third of low-cost adults have behavioral health conditions; among high-cost and ultra-high-cost adults, most have at least one behavioral health condition and one in six has both a mental health and a substance abuse diagnosis. Among the elderly, high-cost and ultra-high-cost enrollees have lower, but still significant, rates of behavioral health conditions. Among children, most high-cost and ultra-high-cost enrollees, as well as more than one-fourth of low-cost enrollees, have a mental health condition.

### **Service Use**

While patterns of service use vary somewhat both by age group and by cost category, SSI enrollees facing mandatory managed care generally make regular visits to primary care providers and have few avoidable hospital stays—two broad indicators of effective utilization. On the other hand, rates of emergency department use are significant, and many beneficiaries do not consult specialists regularly—broad indicators that there is room for improvement in delivering appropriate care to these enrollees.

Three-fourths of high-cost adults and two-thirds of ultra-high-cost adults facing the mandate visit a primary care provider at least four times annually (Table 3). This is an encouraging indication that those with the greatest health care needs have frequent access to primary care and preventive services—although it does not necessarily indicate continuous or appropriate care, nor does it speak to coordination of services under a single primary care physician. It is also noteworthy that about one-third of low-cost SSI adults go a full year without a single primary care visit. Moreover, nearly half of high-cost and ultra-high-cost adults visit a hospital emergency department each year, and one-fourth have two or more such visits annually, despite frequent primary care visits.

Nearly two-thirds of both high-cost and ultra-high-cost adult SSI enrollees facing the mandate visit a specialist each year, and nearly half have two or more visits annually. A third of them, however—along with most of their

**Table 3**  
**Annual Service Use**

	Children (0-17)			Adults (18-64)			Elderly (65+)		
	Low	High	Ultra-high	Low	High	Ultra-high	Low	High	Ultra-high
<b>Primary Care Visits</b>									
None	34%	9%	10%	32%	10%	15%	40%	15%	21%
One to three	34%	22%	16%	24%	15%	18%	25%	14%	15%
Four or more	32%	68%	74%	44%	75%	67%	35%	71%	65%
<b>Emergency Department Visits</b>									
None	74%	52%	48%	71%	53%	52%	85%	70%	69%
One	16%	23%	23%	16%	21%	21%	11%	18%	17%
Two or more	11%	25%	29%	13%	26%	28%	5%	12%	14%
<b>Specialty Visits</b>									
None	79%	62%	59%	58%	34%	39%	60%	30%	38%
One	12%	18%	19%	17%	18%	16%	16%	15%	14%
Two or more	9%	20%	22%	24%	48%	45%	25%	55%	48%
<b>Hospital Admissions</b>									
None	97%	68%	42%	93%	46%	28%	94%	46%	32%
One	2%	22%	26%	6%	29%	18%	5%	37%	22%
Two or more	0%	10%	32%	1%	24%	54%	0%	17%	46%
<b>ACS Hospital Admissions</b>									
None	99%	84%	79%	98%	82%	72%	99%	84%	75%
One	1%	12%	14%	2%	13%	15%	1%	14%	14%
Two or more	0%	4%	8%	0%	5%	13%	0%	3%	12%

low-cost counterparts—go a full year without a single specialty visit. It is difficult to categorize aggregate utilization rates as appropriate or inappropriate, but given the diagnostic patterns of the beneficiaries in question these rates may indicate that enrollees facing the mandate have difficulty gaining access to specialists under fee-for-service Medicaid.

Rates of hospital admission vary strongly by cost category. Inpatient hospital services have the highest unit costs and represent the most expensive form of acute care, however, so rates of hospitalization generally determine enrollees' overall costs—a pattern that typically holds for all patient groups both within and outside Medicaid, and ultimately tells us little. As expected, low-cost enrollees have the lowest rates of hospitalization and ultra-high-cost enrollees have the highest rates of multiple hospital stays.

More instructive are the rates of admission for ambulatory-care-sensitive (ACS) conditions, diagnoses for which timely and effective outpatient care can help avert hospital stays either by preventing the onset of illness, controlling an acute episodic illness or condition, or managing a chronic

disease or condition.<sup>3</sup> The vast majority of SSI beneficiaries, including those in the high-cost and ultra-high-cost categories, have no ACS admissions over a one-year period. Where rates of ACS admissions are high, there lies the potential for cost savings through effective care management that prevents future hospital stays. While preventing ACS admissions among SSI enrollees facing the mandate remains an important goal in itself, there does not appear to be an opportunity to realize substantial Medicaid savings through reductions in avoidable hospital admissions.

### Spending by Service Sector

SSI beneficiaries' use of services under fee-for-service Medicaid indicates that, even after they are required to enroll in Medicaid managed care, a large share of Medicaid payments on their behalf will flow into the fee-for-service delivery system. This pattern will persist because key service areas—behavioral health care (outpatient and inpatient mental health care and substance abuse treatment), outpatient prescription drugs, and personal care (home-care services supporting activities of daily living)—are “carved out” of New York’s Medicaid managed care benefits package.<sup>4</sup> These three service sectors combined account for about half of Medicaid spending on low-cost and high-cost adult enrollees (Table 4). As a result, although these beneficiaries are nominally being enrolled in Medicaid managed care, one of every two dollars Medicaid spends on them may be beyond the control of their managed care plans.

**Table 4**  
**Average Annual Costs per Beneficiary, by Service Sector**

	Children (0-17)			Adults (18-64)			Elderly (65+)		
	Low	High	Ultra-high	Low	High	Ultra-high	Low	High	Ultra-high
Behavioral health services	\$145	\$851	\$2,074	\$316	\$2,680	\$5,196	\$21	\$558	\$1,506
Prescription drugs	396	2,756	6,500	1,768	6,276	8,151	1,053	3,929	5,074
Personal care	0	992	5,695	29	2,778	16,255	9	2,121	15,777
3 major carve-outs (subtotal)	542	4,600	14,269	\$2,113	\$11,734	\$29,602	\$1,083	\$6,609	\$22,357
Hospital inpatient	85	3,096	32,706	317	7,226	42,226	210	7,359	35,603
All other	1,989	9,506	36,958	1,379	5,683	16,449	882	5,338	15,839
<b>Total</b>	<b>\$2,616</b>	<b>\$17,203</b>	<b>\$83,933</b>	<b>\$3,810</b>	<b>\$24,643</b>	<b>\$88,277</b>	<b>\$2,176</b>	<b>\$19,305</b>	<b>\$73,799</b>
Carve-outs as % of total spending	21%	27%	17%	55%	48%	34%	50%	34%	30%

Note: Categories of Medicaid spending may not sum to totals, due to rounding.

<sup>3</sup>Billings J, L Zeitel, J Lukomnik, TS Carey, AE Blank, and L Newman. 1993. Impact of socioeconomic status on hospital use in New York City. *Health Affairs* 12(1):162-173.

<sup>4</sup>Detoxification and withdrawal services are the only behavioral health services included in the Medicaid managed care benefits package for SSI enrollees. For other enrollees, mental health services and some chemical dependence inpatient and rehabilitation treatment are also included.

Among ultra-high-cost adult enrollees facing the mandate, the three major carve-outs account for a lower share but a higher level of spending—an average of \$29,602 per beneficiary. In other words, Medicaid can expect to spend about \$2,500 per month under fee-for-service for each of these new Medicaid managed care enrollees. The share of Medicaid spending devoted to these carved-out services is somewhat lower, but still substantial, for elderly beneficiaries facing the mandate, and significantly lower for children. However, because this analysis does not address school-based health services, which are also carved out of the Medicaid managed care benefits package, it understates spending on carve-outs for children—particularly those in the high-cost and ultra-high-cost categories. The level of spending associated with carved-out services raises a critical question: if a substantial share of Medicaid spending on SSI beneficiaries facing the managed-care mandate bypasses their health plan, are they really being enrolled in managed care?

### **Policy Implications**

Under current policy, SSI beneficiaries in mandatory Medicaid managed care will continue to rely on both the fee-for-service delivery system for some services—behavioral health care, prescription drugs, and personal care—and their new health plans for others, including most primary care, specialty care, and hospital inpatient services. This model is likely to pose challenges to effectively coordinating service delivery under Medicaid. Enrollees will be required to navigate any managed care restrictions on provider choice for services covered by health plans, while directly accessing other services without their plans' prior knowledge. This arrangement raises serious concerns about the ability of health plans to effectively organize care—potentially limiting their ability to improve patterns of service use and manage costs. In turn, New York State will be unable to hold Medicaid managed care plans fully accountable for these enrollees' service use or health outcomes—and Medicaid costs for these enrollees will remain unpredictable.

Two obvious alternatives to the current policy exist, and both are problematic. One is to keep these SSI beneficiaries in fee-for-service Medicaid. This policy option would spare SSI beneficiaries the complications of seeking care from two delivery systems, and would eliminate the restrictions on provider choice under Medicaid managed care. However, fee-for-service

Medicaid's weaknesses are significant: the program has no management structure in place to influence beneficiaries' service use; beneficiaries often have difficulty finding providers who participate in Medicaid; providers face incentives to provide higher-intensity and more costly health care services; and there is limited accountability across the board.

A second policy option is to enroll SSI beneficiaries in comprehensive Medicaid managed care by eliminating the current carve-outs. In addition to having a single entity—in this case a Medicaid managed care plan—responsible for the full range of services that beneficiaries use, the elimination of each major carve-out offers its own potential benefit. Eliminating the behavioral health carve-out would reduce incentives for Medicaid managed care plans, which are responsible for physical health services, to shift costs to providers of behavioral health services, and vice versa. It could also lead to more unified data and administrative systems that support both coordination of care and evaluation of the impact of treatments on overall service use and health outcomes. Eliminating the prescription drug carve-out would allow Medicaid managed care plans to monitor and better manage enrollees' drug utilization, affording opportunities to better target patients for specific interventions and to prevent adverse drug interactions. Eliminating the personal care carve-out would allow plans to deliver home-based services that are better integrated with other health and social services, potentially resulting in shorter hospital stays and fewer hospitalizations.

Eliminating these carve-outs, however, would pose difficult questions and significant challenges. Were such a policy shift to occur, Medicaid managed care plans' first experiences with overseeing behavioral health services, prescription drugs, and personal care would not take place in the context of a pilot or demonstration project but in real time for enrollees who depend on those services. Including these services in the Medicaid managed care benefits package could trigger health plans to subcontract with other entities—such as behavioral health special needs plans, pharmacy benefit managers, and managed long-term care plans—posing new challenges to coordinating and managing enrollees' care. Moreover, the early experience of Medicaid managed care in New York raises questions about the extent to which health plans' control over services has translated into a measurable

impact on the practice patterns of providers and the patterns of service use among enrollees.<sup>5</sup>

As New York enters a new phase in managing the care of SSI beneficiaries—requiring some of these beneficiaries to leave fee-for-service care for the first time—policymakers should reaffirm Medicaid’s clinical priorities and policy goals. These include patient-centered care, provider engagement, coordination of the full range of covered services, measurement of health outcomes, and incentives to reduce overall Medicaid spending. Unfortunately, measured against these priorities and goals, none of the available off-the-shelf choices—Medicaid managed care with or without carve-outs, or fee-for-service Medicaid—appears optimal for SSI beneficiaries facing the mandate. Considering that the current mandate applies to only a small share of SSI beneficiaries who, on average, are significantly less costly than those not facing mandatory Medicaid managed care, effectively serving all disabled and elderly Medicaid beneficiaries will be a substantial challenge. New York’s policymakers—working with health plans, providers throughout the service delivery system, and patient advocates—should prioritize developing models of care for these Medicaid beneficiaries that promote effective service use by patients, coordination among providers, incentives to deliver appropriate and cost-effective care, and a clear framework for responsibility and accountability.

<sup>5</sup> Haslanger K. 2003. *Medicaid Managed Care in New York: A Work in Progress*. New York: United Hospital Fund.

## Appendix: Data and Methods

Data on Medicaid beneficiaries' spending, enrollment, utilization, and diagnostic patterns come from the Medicaid paid claims file provided to the United Hospital Fund by the New York State Department of Health under a data exchange contract. Each fee-for-service Medicaid claim contains detailed data on the beneficiary's basis of eligibility, enrollment status, and diagnoses, as well as on the provider's characteristics and the reimbursement paid for each service rendered. The Center for Health and Public Service Research at New York University's Wagner School of Public Service conducted the statistical programming of the paid claims file.

This analysis is based on the identification of 116,031 SSI beneficiaries in the Medicaid paid claims file who were enrolled in fee-for-service Medicaid in December 2004 and met the State's criteria for mandatory enrollment in Medicaid managed care beginning in 2006. This total represents an 88 percent match with the State's May 2005 estimate of 131,262 SSI enrollees facing the mandate, and a closer match with the State's more recent estimate of 125,000 enrollees. A discrepancy of 12 percent or less in the sample should have no meaningful impact on the findings.

The analysis reports data on spending, enrollment, and utilization from calendar year 2004, and data on beneficiaries' diagnoses on a cumulative basis from 1999 through 2004. Because the average duration of enrollment for SSI beneficiaries facing the mandate approaches 12 months, per capita spending levels would not change significantly if adjusted for full-year enrollment; therefore, this analysis reports actual unadjusted costs.