

**MEDICAID
INSTITUTE**
AT UNITED HOSPITAL FUND

Medicaid Managed Care Reexamined

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Medicaid Institute at United Hospital Fund

James R. Tallon, Jr.
President

David A. Gould
Senior Vice President for Program

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Medicaid Managed Care Reexamined

PREPARED FOR THE MEDICAID INSTITUTE
AT UNITED HOSPITAL FUND BY

Michael Sparer, JD, PhD

MAILMAN SCHOOL OF PUBLIC HEALTH
COLUMBIA UNIVERSITY

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Foreword

Looking back on my participation in the State Legislature’s health policy debate of seventeen years ago—which cemented New York’s commitment to Medicaid managed care—one element stands out in my mind. Consensus was reached only after defenders of a strong and effective Medicaid program were able to broaden the discussion beyond controlling costs, to include improving the delivery of care and use of services. Only then did a proposal born in the budget crisis of 1991 become a vision, and potential vehicle, for genuine Medicaid reform.

As I argued then, the promise of Medicaid managed care is to organize and deliver health care services in a more efficient and effective way—so that beneficiaries receive appropriate care sooner, chronic conditions are better managed, and costly hospital stays and emergency room visits become less common. Managed care is not just about reducing costs, but also about improving the quality, continuity, and coordination of care. Unlike Medicaid cuts that deliver short-term budget savings, managed care holds the potential to truly change how millions of low-income New Yorkers receive the health care services on which they depend.

It has been nearly five years since the United Hospital Fund conducted a broad analysis of Medicaid managed care in New York. That report—written by Kathryn Haslanger in early 2003, when enrollment was at an all-time high—raised significant questions about whether the program was meeting its goals. Since then another million Medicaid beneficiaries have been enrolled in managed care, bringing the total to about 2.5 million.

With reform of the health care system a central focus of state policy development, this is a timely opportunity to once again look closely at the program. This report, by Professor Michael Sparer of Columbia University’s Mailman School of Public Health, takes stock of Medicaid managed care in New York and examines its potential as a platform for meeting the State’s ambitious health policy goals going forward.

Professor Sparer’s report leads me to a second lesson from that long-ago debate. At that time I underestimated the complexity of implementing genuine change. This report’s thoughtful examination of the forces, relationships, successes, and shortfalls of this major initiative remind all who call broadly for health care reform to give attention and respect to the implementation of new ideas.

James R. Tallon, Jr.
President
United Hospital Fund

Executive Summary

Since the early 1990s, New York's health policymakers have promoted Medicaid managed care as a way to change the delivery of health care services, improve quality of care, and control growth in Medicaid spending. Today there are more than 2.5 million beneficiaries enrolled in managed care, and state officials are pressing ahead with efforts to encourage the more than 1.6 million remaining in fee-for-service to enter some type of managed care system. Despite this broad public policy agenda, there are still surprisingly few efforts to examine how well the program is achieving its basic goals.

This report examines eight key issues related to Medicaid managed care in New York.

1. Moving more clients into managed care

Despite the state's well-established managed care initiative, more than 1.6 million beneficiaries and the vast majority of Medicaid's acute care expenditures remain outside managed care. State officials have, however, embarked on a two-part strategy to expand the managed care penetration rates: first, reducing the number of categories under which beneficiaries can be exempt or excluded from managed care, and second, expanding the mandatory managed care initiative to rural communities. Each of these efforts raises important ongoing issues. Which exemptions and exclusions should be removed? How quickly should clients in these categories be required to join a health plan? What care management strategy should the state adopt in rural communities with little or no health plan infrastructure? Should the state establish a primary care case management option for high-risk and/or rural beneficiaries? Answers to these questions are necessary if the state is to make significant additional increases in managed care penetration.

2. Marketing managed care

In New York City, and other communities with well-established managed care initiatives, health plans are fiercely competing for new members, primarily by hiring community-based facilitated enrollers to find persons eligible for Medicaid but not yet enrolled. State officials, concerned about rising health plan marketing costs, have recently imposed a cap on the number of facilitated enrollers and outreach workers plans can have. It is too soon to tell whether that cap will lead to less spending on marketing, or whether health plans will devise alternative marketing strategies. Equally important, it is also too soon to tell if the cap on facilitated enrollers will have an adverse impact on the state's goal of expanding coverage to the uninsured.

3. Reducing client churning

There is strong consensus that too many beneficiaries churn on and off the Medicaid rolls and that such churning is especially problematic in managed care. New York City officials are seeking to reduce enrollment churning by encouraging health plans and large providers to assist clients in the recertification process. New York State officials are focusing their efforts on simplifying the recertification process itself. These various initiatives are promising, but churning is an especially longstanding and hard-to-solve problem that needs to remain high on the state's policy agenda.

4. Benefit carve-outs

In New York, the decision to carve services out of the managed care benefit package is based on several factors, only one of which is the best interest of the beneficiary. The pharmacy carve-out, for example, was prompted by pharmacists' concerns over low health plan reimbursement. Similarly, the behavioral health carve-out was established in large part to protect community-based providers that were not part of traditional managed care networks. Until recently, the impact of the carve-outs on beneficiaries was minimized by the decision to keep most medically complicated cases out of the managed care system. Over the next few years, however, the state expects to require more and more persons with complex medical and mental health needs to enroll in managed care. The mandatory enrollment of SSI beneficiaries in New York City is the beginning of this trend. So far the policy requires such beneficiaries to receive medical care from a managed care plan and behavioral health care from the traditional fee-for-service system. With the current carve-outs in place, it is unclear how—or even whether—meaningful coordination of care can be achieved.

5. Regulating the number of health plans

The Medicaid managed care market in New York City is crowded with health plans fiercely competing—in large part—for each other's current or recent Medicaid enrollees. Consumer advocates, health care providers, state officials, and the large plans all favor a reduction in the number of health plans. In contrast, fourteen upstate counties have only one or two participating health plans, and another twelve counties are without any participating health plans at all. In New York City, the issue is whether the state should aggressively try to steer a market consolidation, either through a system of competitive bidding or through a more regulatory approach, and, if so, what criteria should guide state policy. In more rural communities, in contrast, the question is whether the state should push ahead with a traditional capitated managed care model even where there is little health plan competition, or should instead move toward a system of primary care case management.

6. State reporting of health plan indicators

The state's QARR—Quality Assurance Reporting Requirements—system is the most important element of the effort to evaluate and regulate the managed care initiative. State officials point to QARR scores to show that beneficiaries in managed care do better than their fee-for-service counterparts. State officials also rely on QARR scores to rank and reward health plan performance. Health plans, in turn, expend tremendous resources in an effort to do well on the QARR scorecard. Despite their pivotal role, however, there is still much uncertainty over the reliability of the QARR scores (especially for plans bunched in the middle of the pack), the extent to which QARR is a tool for quality improvement, the utility of the QARR system to evaluate care rendered to beneficiaries such as the severely and persistently mentally ill, much of whose care is carved out of the managed care benefit package, and the extent to which QARR should be used to reward (or punish) plan performance.

7. Setting managed care rates

Beginning in 2008, the state will phase in a new methodology for paying health plans. Under the new system, the state will calculate the average costs for health plans in nine regions, and then adjust that cost (or rate) for each health plan based on the health status of the plan's members. The new system is dramatically different from the current one, under which state and health plan officials negotiate rates based solely on prior and expected costs. Neither the state nor the health plans can easily predict the impact of the new system, although one short-term effect is that several plans are changing the way they pay primary care providers—moving from capitation to fee-for-service—in an effort to improve utilization data collection.

8. Strategies to improve quality care

Health plans utilize two main strategies in an effort to improve the care delivery system: profiling providers, to determine provider compliance with quality standards and to develop targeted plans for quality improvement, and establishing disease and care management programs, aimed primarily at encouraging members to make and keep medical appointments, take all required medications, and follow dietary restrictions. Health plans are also cautiously experimenting with pay-for-performance programs designed to financially reward providers who deliver high-quality care.

State officials have so far adopted a laissez-faire approach to these plan initiatives, focusing their regulatory oversight instead on overall health plan performance, as measured by QARR scores. As the managed care initiative moves forward, however, state officials might well need to adopt a more hands-on approach. One option is for the state to consolidate provider performance data across health plans and to push plans toward more aggressive adoption of a pay-for-performance approach. Given health plans' reservations about the impact they can have on care management, state officials also ought to consider playing a more active role in developing and implementing disease management protocols, perhaps working closely with providers, including integrated delivery systems where possible.

Has Medicaid Managed Care Been Successful?

By all accounts Medicaid managed care has had some impressive achievements. The program today is stable and well-entrenched throughout much of the state. There are office-based primary care doctors who previously declined to treat fee-for-service beneficiaries who now serve those in managed care. Health plans encourage beneficiaries to receive basic preventive services, provide improved access to medical specialists, and often serve as advocates for a needy population. State regulators are far more proactive than when they were simply bill-payers in a fee-for-service model.

Even with these important improvements, however, there remains compelling evidence that the Medicaid managed care initiative has not achieved its underlying goals, and there is ongoing uncertainty over whether the state is pursuing the right managed care strategy:

- [It is hard to pinpoint exactly how the care delivery system for the poor has changed.](#)

Numerous beneficiaries still rely on hospital emergency rooms for primary care. Health plans are no longer permitted to pay a low triage rate for non-emergent care delivered in out-of-network emergency rooms (being required, instead, to pay the same state-determined rate for all out-of-network emergency-room care). Most beneficiaries still do not have an ongoing relationship with a primary care physician, regardless of the requirements and rhetoric of the program. Those beneficiaries who seek care in hospital outpatient departments are still treated primarily by medical residents, a trend especially prevalent in New York City's large academic medical centers. Comprehensive and coordinated oversight of episodes of care is still exceptionally rare.

- **An emerging consensus holds that health plans are in a relatively weak position to modify provider behavior.** By all accounts, the impact of provider profiling tools has been quite modest, especially when (as is most often the case) the percentage of the provider's or clinic's patient population enrolled in a particular plan is low. Similarly, few health plans have implemented pay-for-performance initiatives, nor are plans likely to expand such programs any time soon. Finally, many health plan officials now concede that the best place to house disease management programs is with providers themselves, and that plans (and government) can play at best a supportive role.
- **High levels of enrollment churning still limit care coordination, especially for the chronically ill.** Enrollment churning also complicates and undermines the state's effort to effectively monitor the quality of care, since many QARR variables track outcomes over relatively long periods of time and thus don't count those enrollees who churn out of coverage.
- **No independent evidence exists that the managed care initiative has lowered health care costs.** Part of the problem is that it is extraordinarily difficult to accurately compare managed care and fee-for-service spending. There are also various reasons to be suspicious of cost-cutting claims: health plans have high administrative (and marketing) costs, provider-sponsored plans have little leverage with which to cut the rates paid to their (often high-cost) sponsors, and the state imposes a variety of costly administrative requirements on plans. Even more telling is the extraordinary statistic that while 61 percent of Medicaid beneficiaries are enrolled in managed care, it accounts for only 14 percent of Medicaid spending, primarily because most elderly and disabled beneficiaries are excluded or exempt.

This is a pivotal moment for New York's Medicaid managed care program. The promise of managed care remains clear, both for those now in the program and for those targeted for inclusion. The ongoing challenge, however, is to determine how to turn that promise into better care for all Medicaid beneficiaries.

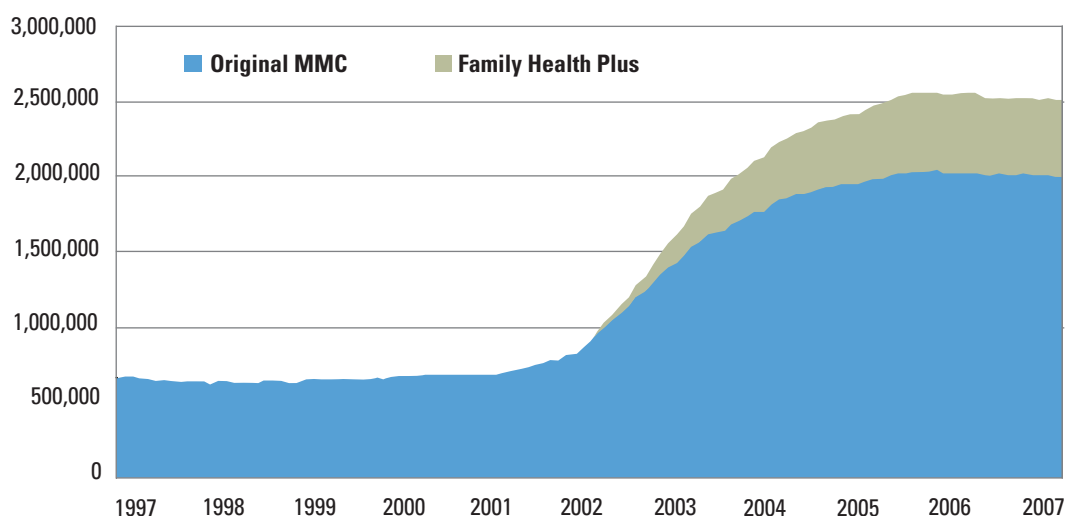
Introduction

Since the early 1990s, New York's health policymakers have promoted Medicaid managed care as a way to change the delivery of health care services, improve quality of care, and control growth in Medicaid spending. Capitated health plans would have an incentive to reduce reliance on expensive care provided in hospitals and other institutional settings. The plans would save money, and improve quality, by providing beneficiaries with office-based medical homes. The new system would emphasize primary care and prevention, educating beneficiaries on the benefits of healthy lifestyles and sending reminders about needed immunizations. Medical offices would provide twenty-four-hour coverage. Beneficiaries would not need to sit for hours in waiting rooms. The needed network expansions would be possible because commercial plans would encourage (or require) physicians to accept both commercial and Medicaid enrollees. To make sure hospitals got the message, health plans would deny payment for care inappropriately rendered in emergency rooms. The large institutionally based delivery system for the poor would slowly lurch toward a new model.

By most accounts, managed care has achieved some of these goals. New York's health care delivery system for the poor is better than it was fifteen years ago, and part of the explanation for that surely is the expansion of the Medicaid managed care initiative. State data suggest, for example, that managed care beneficiaries have better access to good care than do their fee-for-service counterparts (Roohan et al. 2006).

At the same time, however, there have been very few efforts to systematically examine whether and how health plans have actually improved the care delivery system—or whether the state should move even more Medicaid clients into managed care. Nor have analysts considered the program's inner workings, which pose several crucial questions. How effective is the managed care marketing and enrollment system? How can the state reduce the number of beneficiaries who churn on and off the Medicaid (and managed care) rolls? Should the state reduce the number of benefits carved out of the managed care benefit package? What is the right number of health plans in a local market? Does state oversight of plan performance encourage higher-quality care? How can the state use the rate-setting process to improve plan performance? These questions add up to the biggest one of all: is the state pursuing the right strategy with the right model?

Medicaid Managed Care Enrollment, New York State, 1997–2007



Source: United Hospital Fund analysis of New York State Department of Health enrollment reports, March 1997–March 2007

Back in 2003, when there were roughly 1.4 million beneficiaries enrolled in managed care plans, the United Hospital Fund published a study that considered these various issues (Haslanger 2003). That report suggested that managed care had the potential to fulfill its grand promise, but was a long way from doing so. More specifically, the report noted the need for more and better primary care systems to serve as medical homes for beneficiaries, a simplified eligibility and recertification process to minimize client churning, the enrollment of more high-cost and disabled beneficiaries into managed care, and greater centralization of government regulation of the program.

Today there are more than 2.5 million beneficiaries enrolled in managed care, and state officials are pressing ahead with efforts to encourage the more than 1.6 million remaining in fee-for-service to enter some type of managed care system. Despite this broad public policy agenda, there are still surprisingly few efforts to examine how well the program is achieving its basic goals. At the same time, the need for such inquiries is especially timely, given the efforts of Governor Eliot Spitzer's new administration to overhaul and improve the state's health care system. This report is designed to help fill that gap.

It begins with a brief history of the evolution of the state's managed care program, and then offers an overview of the program in terms of its beneficiaries, health plans, providers, and government. The following section reviews what the program is doing well, where it is falling short, and how it might be improved, in eight key areas. These findings are based on more than seventy interviews with government officials, health plan managers, providers, and consumer advocates, along with reviews of dozens of reports, internal documents, and the more general literature on Medicaid managed care. Finally, the report concludes with an evaluation of the program's achievements and some of the ongoing challenges on the Medicaid managed care policy agenda.

Medicaid Managed Care in New York: A Brief History

During the early 1980s, several states, such as Arizona and California, encouraged or required large numbers of Medicaid beneficiaries to enroll in managed care. New York did not join the trend, and by the mid-1980s only twenty thousand or so of New York's two million Medicaid beneficiaries were enrolled in managed care, nearly all of them in a single plan, Health Insurance Plan of Greater New York (HIP).

Several factors prompted New York's reluctance to promote Medicaid managed care. First was the low managed care penetration rate in the state's commercial markets. Prior to 1985, for example, state policy prohibited investor-owned HMOs from operating in New York, and fewer than one million residents were enrolled in any form of managed care. Second, influential interest groups opposed a Medicaid managed care initiative: hospitals worried that Medicaid managed care would threaten their revenue; organized labor feared that non-professional health care workers in those hospitals could lose jobs; and consumer advocates argued that managed care would reduce access to care. Third, the state's Medicaid reimbursement patterns, more than any other state's, favored the more costly care provided in hospital and clinic settings (Burke 2007; Bachrach, Lipson, and Bhandarkar 2006; Sparer 1996), as well as specialty care, and disfavored the office-based primary care physicians that typically play a strong role in managed care networks.

For more than forty years, for example, the state's fee-for-service reimbursement rates paid to office-based physicians have stayed among the lowest in the nation, and comparatively few private-practice doctors have participated in the fee-for-service program. Even small reimbursement increases for office-based care have generally been considered ineffective, since those increases would presumably benefit "Medicaid mills" without luring mainstream physicians. There were occasional efforts to encourage more physicians in certain specialties, such as ob-gyn, to join the program, but these efforts had little impact. By contrast, reimbursement rates for the state's hospital-based providers have been relatively generous, hardly surprising given the state's large and influential academic medical centers. In this context, most Medicaid beneficiaries received care in community health centers, hospital outpatient departments, and hospital emergency rooms. Very few had an ongoing relationship with an office-based primary care provider.

The state's interest in managed care began to grow during the mid-1980s, however, as policymakers looked for ways to alter how Medicaid paid for care in a way that would improve quality and control costs. In 1984, for example, the state legislature provided start-up funds for safety-net providers to form prepaid health services plans (PHSPs),

a new type of HMO that could enroll only Medicaid and other publicly funded beneficiaries. The legislature also authorized counties to establish Physician Case Management Programs (PCMPs), under which physicians would receive enhanced fees in exchange for serving as managed care gatekeepers. The following year, the state's Department of Health finally permitted investor-owned HMOs to enter the state, but required the newly licensed HMOs to "demonstrate a willingness" to enroll Medicaid clients.

Even with these legislative changes, however, few organizations or counties seemed interested in entering the Medicaid managed care market. Only one county (Erie) began a PCMP program. Just five organizations began PHSPs, and these were mainly sponsored by community health centers. The hospital industry expressed little interest in the program. In addition, the investor-owned HMOs that entered the New York market generally did little to enroll Medicaid clients, and the state did even less to enforce the vague requirement that such firms "demonstrate a willingness" to do so. For these reasons, there were still fewer than fifty-thousand beneficiaries enrolled in managed care in the late 1980s.

The policy dynamic changed dramatically, however, in 1991, when the state legislature set a goal of enrolling 50 percent of all eligible Medicaid beneficiaries in managed care by the end of the decade. Two factors account for the new initiative. First, the state faced significant fiscal difficulties, driven largely by rapidly rising Medicaid costs. Expanding managed care enrollment promised fiscal savings (without cutting eligibility, benefits, or reimbursement). Second, the structure of the initiative minimized interest-group opposition: the legislation delegated to the counties the task of developing their own managed care enrollment plans, which were to be phased in over several years. Furthermore, enrollment would be voluntary (unless a county decided otherwise and got federal permission to go mandatory).

As the counties began implementing their managed care initiatives, the commercial HMOs began vigorously competing for the Medicaid market. That newfound interest was due, in part, to a state law, enacted in 1992, that imposed a 9 percent surcharge on hospital bills of HMOs with too few Medicaid enrollees. Even more important, however, was that the state became a generous payer, and HMOs were able to make money on their Medicaid products. At the same time, safety net hospitals, worried about lost Medicaid revenue, began to form PHSPs and compete directly for their own patients. More than a dozen HMOs and PHSPs were soon competing for beneficiaries in New York City and a handful of other counties. The suddenly vibrant Medicaid managed care marketplace prompted significant growth in beneficiary enrollment, from 62,000 in early 1991 to over 300,000 in early 1995.

Buoyed by this success, in the spring of 1995 newly elected Governor George Pataki adopted a two-part strategy for expanding and making more efficient the state's managed care initiative. First, the state requested permission from federal officials to require mandatory enrollment for large numbers of beneficiaries. Second, the state changed its process for setting health plan rates: instead of negotiated plan-specific rates, the state implemented a competitive bidding process. The goal was to have fewer health plans delivering services to a far larger group of enrollees.

Almost immediately, however, there were problems with both parts of Governor Pataki's managed care initiative. The move toward mandatory enrollment, for example, prompted health plans to begin a marketing blitz that resulted in allegations of marketing fraud and inadequate plan capacity. In response, the state temporarily suspended managed care enrollment in September 1995, beginning a slow decline in the number of beneficiaries enrolled. At the same time, the competitive bidding process was enormously controversial, with health plans complaining about draconian rate cuts (and several commercial plans exiting the market).

Despite the setbacks, the state pushed ahead with its request for federal permission to begin mandatory enrollment (although it did abandon competitive bidding by health plans and returned to plan-specific negotiated rates). After nearly two years of bargaining between state and federal officials, the waiver request was approved in July 1997. Under the terms of that agreement, the state began, in 1999, to phase in mandatory managed care; it has continued to do so for the last eight years. For most of that period, the program has operated beneath the political radar screen, with significant (in some years explosive) enrollment growth, a new Medicaid expansion for adults based entirely on a managed care model (Family Health Plus), strong health plan competition, and few complaints or allegations of wrongdoing.

Recently, however, the program has entered a more turbulent time. While some (fairly small) counties are just beginning to phase in mandatory enrollment, the more populous counties have seen a flattening of new enrollment. Meanwhile, state officials are implementing a series of new policies with a major impact on both beneficiaries and health plans. For the first time, for example, the state is requiring some disabled beneficiaries to enroll in managed care. The state is again changing the methodology by which health plan rates are established. And state officials are considering other policies—such as reducing the number of health plans with contracts in downstate communities—that could have an equally significant impact.

The Current Program: A Snapshot

The Beneficiaries

There are approximately 4.2 million Medicaid beneficiaries¹ in the sixty-two counties of New York State. More than 2.5 million (61 percent of them) are enrolled in managed care organizations, while more than 1.6 million remain in the fee-for-service program.² Managed care penetration within Medicaid varies mainly by type of beneficiary and by region. More than three-quarters (76 percent) of non-elderly, non-disabled adults and children are enrolled in managed care;³ by contrast, the penetration rate among the elderly and disabled is only 14 percent. Similarly, the managed care penetration rate in New York City is 68 percent; in the rest of the state it is 46 percent.

Medicaid Managed Care Enrollment (thousands)			
	State	New York City	Rest of State
1997	661	394	267
1998	623	384	239
1999	648	383	265
2000	668	388	280
2001	684	395	289
2002	916	551	366
2003	1,673	1,161	512
2004	2,236	1,607	630
2005	2,470	1,787	683
2006	2,552	1,891	661
2007	2,514	1,860	653

Note: Enrollment is for March of each year. Family Health Plus is included starting in 2002. Figures for regions may not sum to totals due to rounding.

The state’s focus on enrolling children and adults into managed care mirrors national trends. Three factors seem relevant. First, one goal of Medicaid managed care is to discourage beneficiaries from relying on hospital emergency rooms for primary care. Nine-year-old girls with sore throats should not sit for six hours in an emergency room. Second, health plans have traditionally covered working-age families but have had very little experience with the elderly or the disabled. Third, politically organized and influential senior and disability groups have generally resisted mandatory managed care enrollment. Similarly, the state’s focus on highly populated urban areas echoes initiatives in other states. The key variable here is the dearth of managed care organizations in rural communities.

¹ These figures include persons in both the traditional Medicaid program and the Family Health Plus program, a Medicaid eligibility expansion for adults. The numbers do not include approximately 400,000 enrollees in the Child Health Plus B program, which is New York’s State Children’s Health Insurance Program (SCHIP).

² These figures—and all other enrollment data reported, unless otherwise specified—are based on March 2007 enrollment data.

³ Unless otherwise specified, “children” and “adults” refer to Medicaid eligibility categories that exclude the elderly and disabled.

At the same time, the state has also begun an effort to expand traditional managed care to the high-cost and medically complicated elderly and disabled populations. In March 2007, for example, the state ended the exemption from managed care enrollment for Supplemental Security Income (SSI) beneficiaries with severe and persistent mental illness who reside in New York City.

The Health Plans

There were twenty-seven health plans participating in New York State's managed care initiative as of March 2007.⁵ While several plans compete in multiple counties, only New York State Catholic Health Plan (formerly—and still widely known as—Fidelis Care), in forty counties, is moving toward a statewide presence. In general, the health plan marketplace varies significantly by geographic region. In New York City, for example, there were seventeen participating health plans as of March 2007, leading to a crowded and fiercely competitive market. Other downstate counties (such as Nassau and Westchester) also have competitive markets, but with fewer—only five to six—participating plans. In more rural upstate New York, most counties with mandatory managed care have only one or two health plans.

The twenty-seven participating plans include twelve that are provider-sponsored, mostly by hospitals but some by community health centers. These are licensed as PHSPs and, with a couple of limited exceptions, exclusively serve public health insurance programs. The remaining fifteen plans, generally referred to as commercial HMOs, consist of five that market only to public insurance beneficiaries, and ten that operate in both the employer- and government-sponsored markets.

PHSPs dominate the market in downstate communities, with 70 percent of market share in New York City and a smaller majority of enrollment in other downstate counties. One explanation is that several commercial HMOs left the New York City market during the mid-1990s battle over competitive bidding, encouraged in part by the state's 1996 repeal of the 9 percent surcharge imposed on hospital bills paid by HMOs with too few Medicaid enrollees. Other plans (mainly public insurance-only HMOs), most of which entered the market several years after the commercial plans exited (and after the PHSPs were already well established), have not gained as high a share. Also aiding the hospital-based PHSPs is their ability, in many cases, to enroll most of the beneficiaries who regularly use their sponsoring facilities. Interestingly, commercial HMOs have done far better in upstate communities, mainly because the large upstate hospital systems have generally contracted with existing health plans rather than creating their own.

⁵ Since March 2007, Community Premier Plus has ceased operations. This figure does not include special needs plans (SNPs) or partial capitation plans, which are paid to provide only part of the Medicaid managed care benefit.

Medicaid Managed Care Plans in New York State, March 2007

Affinity Health Plan
Americhoice of New York
Amerigroup (formerly Careplus)
Capital District Physicians Health Plan
CenterCare
Community Choice Health Plan of Westchester
Community Premier Plus
Excellus (Monroe Plan for Medical Care)
GHI HMO Select
Health Insurance Plan of Greater New York
HealthFirst PHSP
HealthNow/BCBS-WNY/Community Blue
HealthPlus
Hudson Health Plan
Independent Health Association
Managed Health Inc./A+ Health Plan
MetroPlus Health Plan
MVP Health Plan
Neighborhood Health Providers
New York-Presbyterian Community Health Plan
New York State Catholic Health Plan (Fidelis Care)
Rochester Area HMO/Preferred Care
SCHC Total Care
Suffolk Health Plan
United Healthcare Plan of NY
Univera Community Health
Wellcare of New York

Note: Provider-sponsored plans are shaded. In addition to these plans, the following serve public program beneficiaries only: Americhoice, Amerigroup, Managed Health Inc., Univera Community Health, and Wellcare.

The Providers

More than any other state, New York's traditional fee-for-service Medicaid program has long favored hospital-based outpatient care and federally qualified health centers, while disfavoring office-based primary care. Despite having the nation's most costly Medicaid program, for example, New York has consistently ranked at the bottom among the states in the ratio of Medicaid physician fees to both Medicare-allowed charges and private fees. This fee structure reflects a longstanding pattern, especially in the larger downstate communities, of relatively few office-based primary care physicians with privately insured patients accepting Medicaid fee-for-service beneficiaries in their private practices. The movement to managed care promised to enlarge the pool of participating primary care

physicians, both because the health plans can (and generally do) pay higher rates by reallocating “savings” from reduced hospital use, and also because plans that served both commercial and public markets presumably would require providers to accept both groups of members.

The health plans have been fairly successful at signing up large numbers of primary care providers, including many who previously refused to see Medicaid enrollees. This is especially true upstate. Monroe Plan for Medical Care (the Monroe Plan), for example, has contracts with every primary care provider in Monroe County, and with 80 percent of the providers in the nearby Southern Tier. Health plans in New York City and other downstate communities also list large numbers of participating providers, although plan officials acknowledge that most beneficiaries still receive primary care in hospital-based outpatient departments or community health centers. As discussed later in this report, it is hard to document the extent of improved primary care access, though by all accounts it is better than it was.

There is, to be sure, much overlap among the health plan networks, with most clinics and even office-based physicians signing as many contracts as they can. There is somewhat less overlap, however, for inpatient hospital care. Two patterns have emerged. First, the commercial public insurance-only health plans, such as Wellcare, typically have contracts with several community hospitals, but not with the more expensive academic medical centers. Second, some large hospital systems, such as the New York City Health and Hospitals Corporation (HHC), are increasingly inclined to sign contracts only with their own sponsored plans, in the case of HHC the MetroPlus Health Plan (MetroPlus).

Government Oversight

For more than forty years, New York State has had one of the most decentralized Medicaid programs in the nation. Some analysts have suggested that one explanation for the high cost of the state’s program was the unusually influential role played by provider groups, labor leaders, insurers, and consumer advocates, all of whom have had an interest in an expanded and more generous program (Sparer 1996). Others have suggested that the multiple government agencies responsible for various aspects of program management have made it difficult to develop coordinated policy and overarching principles (Bachrach, Lipson, and Bhandarkar 2006).

The lead agency in this complicated policy arena is the State Department of Health (SDOH). Other state agencies are responsible for program policy as it affects persons with mental illness, developmental disabilities, and substance abuse conditions. And fifty-eight local social services districts determine program eligibility (under state supervision), pay roughly 17 percent of the Medicaid bill (Birnbaum 2005), and (in the case of New York City) sign and oversee managed care contracts.⁶

⁶ The local share of Medicaid costs will decline over time, due to a 2005 state law that caps future increases in local Medicaid costs at 3 percent annually.

An early priority of Governor Eliot Spitzer's administration was to reduce this fragmented state oversight. The first target was the internal organization of SDOH, which had long divided responsibility for its tasks among several relatively autonomous units. Under that organizational chart, the Department's Office of Medicaid Management set eligibility and benefit policy, and determined reimbursement for office-based physicians; its Office of Health Systems Management determined reimbursement rates for institutional providers; and its Office of Managed Care was generally responsible for the managed care program.

Shortly after taking office, the Spitzer administration revealed a revised SDOH organizational structure, spearheaded by a new Office of Health Insurance Programs (OHIP), which would regulate Medicaid, Family Health Plus, and Child Health Plus, and provide more coordinated oversight of the program, including the managed care initiative. The consolidation of Medicaid functions in OHIP is occurring at roughly the same time as implementation of the recently enacted cap on local Medicaid expenditures. These two developments will surely change the relationship between the state and the local social services districts, although the details of such changes are still uncertain.

Medicaid Managed Care: Eight Key Issues

1. Should the State be Moving More Clients into Managed Care?

More than a decade after New York began its mandatory managed care program, nearly 40 percent of the state's 4.2 million beneficiaries still receive care through the traditional fee-for-service system. These fee-for-service clients can be divided into three categories: persons who are excluded or exempt from managed care enrollment, persons who reside in a rural county in which managed care is not mandatory, and persons who are required to be in managed care but have not yet transitioned into a health plan.

Beneficiaries Excluded or Exempt from Managed Care Among New York's Medicaid beneficiaries, 1.3 million are excluded from managed care (i.e., prohibited from joining a health plan) or exempt from it (i.e., permitted but not required to enroll in a plan). These generally are among the most medically complicated, and thus most expensive to treat and manage, beneficiaries in the state. Those excluded, for example, include nursing home residents, low-birthweight babies, and persons residing in state psychiatric facilities. Similarly, the exempt category includes persons who are HIV+, dual eligibles (those on both Medicaid and Medicare), and residents of facilities for the developmentally disabled. Given the exceptionally high medical bills incurred by many of these populations, only 14 percent of the state's overall Medicaid bill is paid through Medicaid managed care.⁷ Excluding long-term care services and disproportionate share hospital payments, managed care's share of Medicaid spending is still only 28 percent.⁸

⁷ United Hospital Fund analysis of CMS Form 64.

⁸ United Hospital Fund analysis of CMS Form 64.

Medicaid Managed Care Penetration (enrollment in thousands), March 2007			
	State	New York City	Rest of State
Children and adults			
Managed care	2,369	1,763	605
All Medicaid	3,109	2,123	985
MMC penetration	76%	83%	61%
Elderly and disabled			
Managed care	145	97	48
All Medicaid	1,044	601	443
MMC penetration	14%	16%	11%
All beneficiaries			
Managed care	2,514	1,860	653
All Medicaid	4,152	2,724	1,428
MMC penetration	61%	68%	46%
Note: Categories may not sum to totals due to rounding. MMC = Medicaid Managed Care			

Over the past few years, state policy has begun encouraging more beneficiaries with medically complicated cases to enroll in managed care. The state's goal is both to better coordinate clients' care and to save dollars. The push began in November 2005 with a program in New York City to require 125,000 SSI beneficiaries to enroll in a health plan (Shure 2006; Birnbaum and Billings 2006). By most accounts, this initial effort has progressed without major problems, both because of a gradual phase-in (no more than 10,000 SSI beneficiaries a month have been required to enroll) and because most of the new enrollees have physical but not mental disabilities, and thus are able to ask questions and effectively advocate for their needs. The state implemented mandatory managed care for SSI beneficiaries in additional counties, starting in the fall of 2007.⁹

To be sure, some consumer advocates are less sanguine, pointing to the remarkably small body of data on how SSI clients are doing in managed care. Consumer advocates also raise concerns about whether health plans are meeting the standards of the Americans with Disabilities Act in communicating with these clients (the requirement, for example, that large-print materials be sent to the visually impaired). There are also questions about whether provider offices meet ADA standards (of wheelchair accessibility, for example) and whether clients have adequate access to specialists. Nonetheless, even consumer advocates agree that the transition is proceeding relatively smoothly for most of the physically disabled beneficiaries who were the first targets of the new initiative.

⁹ The initial five counties are Nassau, Onondaga, Oswego, Suffolk, and Westchester.

Far more controversial, however, was the state's decision to end, as of March 1, 2007, the exempt status of those SSI beneficiaries in New York City who are seriously and persistently mentally ill. From the state's perspective, this is simply another incremental effort to require a medically complicated, high-cost group of patients to join a health plan and presumably receive more coordinated and comprehensive health care. State officials also point out that the behavioral health services needed by these beneficiaries are carved out of their managed care benefit package and therefore will still be delivered by their traditional providers and paid on a fee-for-service basis. Indeed, roughly 75 percent of Medicaid spending on this population will remain in the fee-for-service system, given their need for behavioral health services and prescription drugs (Birnbaum and Powell 2007).

Several concerns make consumer advocates and even health plan officials far less positive about this change. First, there is little likelihood that these beneficiaries will receive truly coordinated care. Instead, most will receive care from two very different delivery systems: the health plans will provide medical services, while traditional mental health clinics—which are rarely in managed care networks—will provide mental health services. Second, the traditional health plans, by their own admission, have little experience caring for a severely mentally ill population. Even more troubling, most health plan officials acknowledge that they have done very little planning for the coverage of this population. Third, these beneficiaries are unlikely to have the wherewithal to negotiate this new and complicated change themselves, imposing a significant burden on family members, consumer advocates, health plan care managers, and public officials to supervise and manage the transition. It is too soon to tell, however, whether this safety net will provide sufficient protection. Nor is it clear whether the presumed benefits of the transition to managed care will exceed the care disruptions generated by the shift.

For all of these reasons, several consumer advocates suggest that instead of moving persons with complex needs into traditional health plans, the state should develop an enhanced primary care case management program (PCCM), under which the state itself would contract directly with primary care providers to act as gatekeepers to specialty care, and with disease management vendors to coordinate services provided to those with special needs. Alternatively, the state could enter into full or partial capitation contracts with special needs health plans. Other states are already implementing these and similar initiatives (Bella, Goldsmith, and Somers 2006).

While acknowledging these concerns and suggestions, state officials insist that there is little early evidence of any major problems in the effort to move SSI beneficiaries into traditional health plans. While providing assurances that they are carefully monitoring the pilot effort, state officials clearly hope to soon replicate that effort in other counties. Moreover, state officials are also eager to reduce even further the number of exclusions and exemptions, and to encourage or require more and more medically complicated and high-cost beneficiaries to enroll in managed care.

The state has, in this vein, continued to expand its managed long-term care demonstration program. Beginning in September 2007, for example, Wellcare began offering a managed care product in which enrollees receive long-term care services, as well as traditional medical services, through a single health plan. This demonstration program goes well beyond prior managed long-term care offerings, in which enrollees received long-term care from a managed care plan and traditional medical services through fee-for-service. (There are sixteen of these more limited managed long-term care plans throughout the state, all but one provider-sponsored). Still, the state has not suggested that it hopes to adopt the Arizona model, under which beneficiaries are required to receive all services, including long-term care services, from a single health plan (Sparer 1999). Such a proposal would, however, no longer be a surprise, especially if the state could also require dual Medicare-Medicaid enrollees to receive all their care from a single plan. So far, however, federal officials have not allowed any state (even Arizona) to impose mandatory managed care on duals.

Rural Beneficiaries without Access to Managed Care These initiatives to encourage more beneficiaries to enroll in managed care have also led the state to expand its efforts in rural communities. In part, this required convincing the state legislature to amend a law prohibiting mandatory managed care if there were fewer than two competing health plans. The changed law, enacted in 2006, allows mandatory enrollment even if there is only one participating health plan, in counties designated as rural. Shortly after the new law's enactment, state officials required fourteen additional counties to phase in a mandatory managed care initiative. Even with this expansion, however, there are still twelve counties that do not have any participating health plans. The 50,000 beneficiaries who live in these twelve counties all participate in the fee-for-service Medicaid program. Developing a care management strategy for these rural beneficiaries is an important and vexing challenge. One option is to induce one or more health plans to enter these rural markets. A second option is to develop a primary care case management program under which the state itself would serve as the overall care management entity.

Beneficiaries Transitioning to Managed Care There are 350,000 beneficiaries who are required to enroll in managed care and are slowly transitioning into a health plan. These beneficiaries can themselves be divided into three groups: 50,000 live in one of the fourteen counties just now shifting to mandatory managed care; 100,000 are SSI beneficiaries who live in New York City and are also just now transitioning into managed care; and 200,000, mostly New York City residents, have recently enrolled in Medicaid and have up to three months in which to join a health plan.

The only way state officials could make a significant dent in these numbers would be to require faster managed care enrollment for those beneficiaries who are neither exempt nor excluded, instead of giving new beneficiaries months to sign up for a plan. State officials seem reluctant to pursue this option, and instead suggest that they only expect about 90 percent of those eligible for managed care to be enrolled at any given time.

Policy Summary: Moving More Clients into Managed Care Despite the state's well-established managed care initiative, more than 1.6 million beneficiaries and the vast majority of Medicaid's acute care expenditures remain outside managed care. State officials have, however, embarked on a two-part strategy to expand the managed care penetration rates: first, reducing the number of categories under which beneficiaries can be exempt or excluded from managed care, and second, expanding the mandatory managed care initiative to rural communities. Each of these efforts raises important ongoing issues. Which exemptions and exclusions should be removed? How quickly should clients in these categories be required to join a health plan? What care management strategy should the state adopt in rural communities with little or no health plan infrastructure? Should the state establish a PCCM option for high-risk and/or rural beneficiaries? Answers to these questions are necessary if the state is to make significant additional increases in managed care penetration.

2. Picking a Health Plan: How Good is the Marketing and Enrollment System?

Medicaid programs can inform beneficiaries of their managed care options in several ways. One approach is to permit health plans to market directly to beneficiaries, simply notifying the state of clients' health plan choices. The advantage of this model is that health plans can tout their virtues (and networks) to eligible persons who might otherwise not sign up for Medicaid. The disadvantage is that health plan marketers may not provide clients with an even-handed view of the market, and may even provide false information to induce enrollment.¹⁰

At the opposite end of the spectrum, states can prohibit health plan marketing and rely on state (or county) workers to inform beneficiaries of their choices. The advantage here is that clients presumably get an unbiased overview of their options as part of their eligibility (or recertification) process. One disadvantage is cost, especially when there are multiple plans (and thus a complicated education process) and strong public employee unions (and thus relatively highly compensated workers performing the task). Another problem is that smaller niche-based plans are likely to have less name recognition than their larger competitors, and are unlikely to survive without the ability to market directly to clients.

Alternatively, states can hire "enrollment brokers," companies that handle every aspect of the marketing and enrollment process, from notifying clients of their enrollment options to developing systems to ensure that clients properly recertify their eligibility. Enrollment brokers can offer unbiased advice on health plan options, as well as broad experience in every aspect of the enrollment process, often at a relatively low cost. At the same time, states need to carefully oversee every aspect of the broker contract, making sure clients receive good information in a timely fashion. One test of performance in a mandatory managed care program is the percentage of clients who fail to select a plan themselves, and are thus assigned a plan through some pre-determined formula. The goal, of course, is a low auto-assignment rate, reflecting an educated and engaged beneficiary population.

¹⁰ These risks are illustrated by the decision of seven insurers to temporarily suspend marketing and sales of their Medicare Part D plans in response to concern about "rogue" brokers who were deceiving clients (BNA 2007).

Prior to the mid-1990s, New York State allowed health plans nearly unfettered authority to directly market to and enroll Medicaid beneficiaries. The system seemed to work fairly well during the slow-growth early 1990s, but during the summer of 1995, following then-Governor Pataki's announcement that he was seeking federal permission to go mandatory, health plans began a massive and controversial marketing campaign. Consumer advocates were soon accusing several plans of marketing fraud. Some plans were accused of misrepresenting facts, telling clients they already needed to sign up with a health plan, for example. Others were allegedly enrolling more clients than they had the capacity to serve. While the extent of actual wrongdoing was unclear, government auditors did uncover some marketing misdeeds, and in August 1995 the state temporarily suspended direct plan marketing and enrollment (Sparer, Brown, and Kovner 1999).

While the ban on plan marketing was temporary and quickly lifted, government oversight of the entire process became far more rigorous, with both state and local officials playing key regulatory roles. Medicaid officials also hired an enrollment broker, Maximus, to play a key role in various aspects of the enrollment process.

As with most aspects of the state's Medicaid program, the marketing and enrollment dynamic varies dramatically throughout the state, with especially sharp differences between upstate and downstate, primarily because the health plan marketplace in the two regions is so different.

New York City In 1998, as New York City began its effort to convert hundreds of thousands of beneficiaries from fee-for-service to mandatory managed care, it hired Maximus, the enrollment broker, to help with the process. Maximus sent letters to current beneficiaries telling them they would be assigned to a health plan unless they voluntarily selected one within 90 days, letting them know their options, and providing a toll-free telephone number for advice. Maximus also began providing a similar set of options to newly enrolled beneficiaries, as city Medicaid eligibility workers referred them to the broker. More recently, it is Maximus that has notified SSI beneficiaries that they have lost their exemption from managed care enrollment, and that they too must now choose a plan or be assigned to one. Maximus has generally done a good job in handling this process: there have been relatively few complaints by beneficiaries or advocates, and less than 10 percent of beneficiaries have been assigned to health plans, an auto-assignment rate that is low by national standards.

Over the last couple of years, however, the focus has shifted from moving fee-for-service clients into managed care to finding persons eligible for Medicaid but not enrolled. Indeed, 88 percent of new managed care enrollees in New York City are persons who were previously uninsured, including those whose Medicaid coverage recently lapsed at renewal. Only 5 percent are persons transferring from Medicaid fee-for-service (via Maximus), while 7 percent are persons transferring from one health plan to another. This shift has changed the Maximus role. While the broker still provides guidance to new applicants who make their way to a Medicaid office, most new managed care enrollees are now signed up by health plan staff—community-based outreach workers, known as facilitated enrollers, who can both help clients fill out their Medicaid application forms and at the same time sign them up with a health plan.

This shift in the source of managed care enrollments has had an enormous impact on the crowded health plan market. Every health plan has facilitated enrollers in the field (although plans vary in the extent to which they rely on such enrollers) and these marketers compete aggressively with each other, and with facilitated enrollers working for community-based organizations (such as the Children’s Aid Society). By early 2007, some health plans had hundreds of facilitated enrollers scattered throughout the city. Many of these enrollment specialists work out of large “community outreach vehicles” parked on city streets (and often drawing complaints from local business people). Others are assigned to clinics or hospitals. Still others move regularly around local neighborhoods, working at health fairs, local businesses (such as large department stores), and schools.

City and state Medicaid officials jointly regulate these health plan marketing efforts. For example, health plans are required to submit to the city a schedule of when and where their facilitated enrollers will be working. The city also has field staff who audit plan marketing efforts by pretending to be applicants. The state supplements the local auditing efforts by requiring health plans to have a “secret shopper” program, to deter marketers from providing false or inaccurate information. The state also prohibits health plans from paying commissions to facilitated enrollers (although plans can pay bonuses of up to 10 percent of salary based on a host of performance measures).

While complaining vigorously about this increased regulatory oversight, many health plans continue to hire more and more facilitated enrollers and rely more and more on the new members they generate.¹¹ One plan went from 120 facilitated enrollers in 2002 to over 500 in early 2007. Another charges that a competitor is luring away its top facilitated enrollers by offering large signing bonuses. The trend reflects the extraordinary competition within the New York City market: the seventeen health plans (as of March 2007) are competing for new enrollees in a relatively saturated managed care environment. Moreover, hospital-sponsored plans are increasingly persuading their owners to bar competitors from marketing in hospital waiting areas, prompting even fiercer competition on the streets and at local events. In 2006, for example, the Health and Hospitals Corporation barred plans other than MetroPlus from most of its waiting areas, and although HHC now permits access to HealthFirst as well, most other plans are still barred.

One benefit of the fierce health plan competition is a modest reduction in the number of uninsured. A large percentage of the uninsured are eligible for public coverage but do not know of their eligibility, are deterred by the administrative hassle of enrollment, or are worried that their immigration status could be undermined if they (or their children) were to enroll in public programs. Facilitated enrollers, who typically speak the language and share the demographic characteristics of the communities in which they work, are adept at finding, educating, and enrolling many of these persons. This outreach and education function will be especially important as the state implements its planned expansions in child health coverage.

At the same time, city and state officials are concerned about both the cost of health plan marketing and the possibility of illegal marketing activities. The New York State attorney general's office, for example, is investigating whether one or more plans have illegally paid bonuses to marketers based on the number of new enrollees they signed up. In October 2007, HealthFirst temporarily suspended efforts to enroll new members pending results of the investigation. In addition, while city and state officials acknowledge the unintended benefit of the competition (the outreach to the uninsured), they also worry that plans are spending too much money trying to lure clients from each other, and that the growing competition is often confusing to beneficiaries, who are regularly besieged by marketers and who occasionally sign up with more than one plan simply because they are confused.

¹¹ The only exception to this rule seems to be HIP, which relies instead on its name recognition.

For these reasons, state officials recently imposed a cap on the number of facilitated enrollers and outreach workers for each plan: 150 in New York City, and 75 outside the city. The state also capped the number of community outreach vehicles in New York City at five per plan, with no more than one at any given time in Manhattan, and imposed additional restrictions on how plans compensate facilitated enrollers and outreach workers. The cap will mean fewer facilitated enrollers on the streets, at least for some large plans, which will change the extent of managed care marketing. It is hard to predict how health plans affected by the cap—especially those that focus their marketing around large numbers of facilitated enrollers—will respond to the changed marketing rules. It is also unclear whether the cap will limit effective outreach to the uninsured.

The Upstate Counties The marketing and enrollment process is much less controversial in most upstate communities, largely because there are fewer competing health plans. Two counties—Monroe, which includes the city of Rochester, and Ulster, a relatively rural region in the Hudson Valley—are illustrative. Monroe County has, for years, required families with children to enroll in one of two health plans: the Monroe Plan (which operates under a contract with Excellus) or Preferred Care. The two plans have essentially the same provider networks, and neither engages in much marketing. County officials inform new beneficiaries of their options upon enrollment, and most pick a plan as part of the application process. The Monroe Plan has the large majority of enrollees (almost triple the number of its competitor), but neither plan has more than a few facilitated enrollers.

Ulster County just began phasing in mandatory enrollment in March 2007. Like the other thirteen counties that are part of this latest expansion phase, Ulster was given a choice of hiring Maximus (at state expense) to handle the transition, or relying on county workers. Ulster is one of ten counties that decided to use Maximus. By all accounts, the transition has so far proceeded smoothly. Maximus has two staffers in the Ulster County Medicaid office to explain health plan options to new enrollees. It has also begun to contact current beneficiaries—either when their eligibility needs to be recertified or when there is some other activity on their case—to inform them of the need to transfer to one of five participating plans: GHI HMO Select (GHI), Hudson Health Plan, MVP Health Plan, Wellcare, or Fidelis Care. The health plans do have some facilitated enrollers in the field, and are engaging in local advertising (both newspaper and billboard) in an effort to develop name recognition among beneficiaries. So far, however, most outreach, education, and enrollment is being done by Maximus.

Policy Summary: Marketing Managed Care In New York City, and other communities with well-established managed care initiatives, health plans are fiercely competing for new members, primarily by hiring community-based facilitated enrollers to find persons eligible for Medicaid but not yet enrolled. State officials, concerned about rising health plan marketing costs, have recently imposed a cap on the number of facilitated enrollers and outreach workers plans can have. It is too soon to tell whether that cap will lead to less spending on marketing, or whether health plans will devise alternative marketing strategies. Equally important, it is also too soon to tell if the cap on facilitated enrollers will have an adverse impact on the state's goal of expanding coverage to the uninsured.

3. Reducing Churning: What Strategies Can Keep Beneficiaries Enrolled?

Medicaid beneficiaries generally are required by federal law to recertify their eligibility annually; however, large numbers of beneficiaries do not produce the required documentation. Back in 2000, for example, one study found that nearly 50 percent of beneficiaries were involuntarily removed from the program because they failed to properly recertify (Bachrach and Tassi 2000). Rather remarkably, only a small minority of these persons have actually become ineligible for coverage (Lipson et al. 2003). Most simply fail to provide the needed paperwork, at least until they again seek health care and are encouraged to reapply by their provider. The result is ongoing enrollment churning (Boozang, Braslow, and Fiori 2006).

High levels of enrollment churning are especially problematic in a managed care environment. Health plan disease and care management programs are disrupted when large numbers of clients move on and off the rolls. Beneficiaries who churn off the rolls are less likely to receive preventive care. Health plans are more likely to deny payment for services delivered to persons who have churned off and back on the rolls, perhaps because the plans are often asked to pay for services that are retroactively covered, and thus were never pre-authorized. Health plans, providers, and government officials incur high administrative costs in seeking to minimize churning and its consequences.

Provisions in the New York Health Care Reform Act of 2002 (HCRA) sought to simplify the recertification process and thereby reduce the level of enrollment churning. HCRA eliminated the requirement that the recertification process include a face-to-face interview, and eliminated much of the required recertification documentation. As a result, beneficiaries are now able to renew their coverage through the mail, using a shorter and simpler form. Many local districts even preprint most of the client's personal information on the form, leaving blank only the boxes for income and assets.

Medicaid officials in New York City suggest that the transition to mail recertification has had a significant effect on churning, improving the retention rate from roughly 47 percent to approximately 65 percent. Other analysts are more skeptical. A recent report from the Coalition of Prepaid Health Services Plans acknowledges that more beneficiaries are returning recertification paperwork, but suggests that the rate of involuntary disenrollment still hovers at just under 50 percent (Boozang, Braslow, and Fiori 2006). Part of the apparent drop in retention in 2005 was due to a federal audit of New York City's mail recertification process, which found that city workers were not adequately reviewing beneficiary documentation. City workers responded with more rigorous documentation demands, leading to the reduced retention rates.

Health plan officials believe retention rates are now as low as they were prior to the HCRA reforms. Every plan interviewed for this analysis reports a monthly disenrollment rate of 4 to 5 percent—or 48 to 60 percent annually. The result is that plans need to enroll large numbers of new members simply to maintain flat overall enrollment. Fidelis Care, for example, reports enrolling 168,589 new members in 2006, while disenrolling 170,146 that same year, for a net loss of 1,557 members. Other plans report similar enrollment-to-disenrollment ratios.

In New York City, two programs to reduce enrollment churning have been recently introduced. The first provides health plans with weekly reports on their members' renewal status; the plans then assign facilitated enrollers to assist members in the recertification process. It is too soon to tell if the program, which began in November 2006, is reducing the churning rate. It is also too soon to tell if the program is cost-effective, especially since much of the plans' outreach is to beneficiaries who have already recertified. Finally, it is uncertain if the recently imposed cap on facilitated enrollers will limit these health plan outreach efforts. Despite these concerns, however, both Medicaid officials and the plans themselves are optimistic about the program.

City officials are also hopeful about a program designed to enable providers to help clients recertify. In the first iteration of this effort, the City's public hospital system matches its patient appointment report with a list of clients due for recertification. Hospital staffers then ask those persons to bring the needed renewal forms and documentation to their appointments. The goal is to submit the forms during those appointments.

The state health department is supportive of the two city initiatives. At the same time, its focus is on further simplifying the renewal process, rather than relying on health plans or providers to assist clients in navigating the current process. State officials are working to implement a recent law allowing beneficiaries to simply attest to their income and residency at renewal. In addition, they would like to increase the time between recertifications, and enable persons to recertify electronically. These officials are also looking at retention strategies used in other states. Arkansas, for example, is experimenting with telephone renewals (Covering Kids and Families 2007).

The state is also concerned, however, about balancing the desire for less churning against the need to avoid fraudulent enrollment or, more often, enrollment errors. Because of administrative errors, for example, thousands of beneficiaries in New York City have been assigned more than one Medicaid identification number. While these duplicate enrollments are typically unintentional, one result is that health plans are sometimes paid twice for the same client, or two plans are paid for the same client. As a result, the state comptroller, Medicaid inspector general, and attorney general are conducting audits. Two companies have already settled: HealthFirst has reimbursed the state \$6 million for 6,000 duplicate enrollees, while Partners in Health (now closed) has agreed to return \$902,000 (Sullivan 2007). Pending the various audits' outcomes, the state has developed a "retroactive disenrollment program" designed to recoup duplicate payments from health plans. (There is no program yet in place to recover payment when two separate plans are paid for the same client.) While the health plans and the state both acknowledge that the problem stems from faulty Medicaid enrollment files, the plans complain that Medicaid officials take too long to respond to requests to resolve problems with duplicate identification numbers. The plans also point out that it is hard for them to recoup payments from providers when state officials determine that wrongful payments were made.

Policy Summary: Reducing Client Churning There is strong consensus that too many beneficiaries churn on and off the Medicaid rolls and that such churning is especially problematic in managed care. New York City officials are seeking to reduce enrollment churning by encouraging health plans and large providers to assist clients in the recertification process. New York State officials are focusing their efforts on simplifying the recertification process itself. These various initiatives are promising, but churning is an especially longstanding and hard-to-solve problem that needs to remain high on the state's policy agenda.

4. Should the State Reduce the Number of Benefit Carve-Outs?

States have significant discretion to determine which Medicaid-covered benefits should be delivered through managed care. Only Arizona, for example, requires beneficiaries to obtain long-term care services through a managed health plan. States generally carve long-term care out of their managed care initiatives, both because health plans are typically inexperienced in managing such services and because providers and beneficiaries have long resisted their inclusion. States carve out other services, as well, for similar reasons. In the area of behavioral health, for example, commercial health plans generally subcontract services to specialized behavioral health plans. State Medicaid agencies can, therefore, choose to: 1) include behavioral health in the regular managed care package, letting health plans subcontract or not; 2) contract directly with behavioral health plans; or 3) carve behavioral health out of managed care altogether, instead continuing to pay traditional behavioral health providers on a fee-for-service basis.

Like nearly every other state, New York carves out long-term care services, although it is experimenting with voluntary managed long-term care demonstration programs. The state also makes coverage of dental care and family planning services optional. Clients enrolled in health plans that choose not to cover those services receive them through the traditional fee-for-service program—as in the case, most notably, of Fidelis Care, whose clients must obtain family planning services through the fee-for-service system. As a Catholic-owned health plan, Fidelis Care is very unlikely to add coverage of family planning services. For many other health plans, it is dental care that is excluded, because of the extraordinarily low proportion of dentists accepting Medicaid patients. While there is no evidence of whether clients who access these services through managed care do better or worse than their fee-for-service counterparts, state officials generally favor more inclusive health plan coverage.

More controversial is the state's decision to carve out pharmacy services and behavioral health care for the severely mentally ill.

The Pharmacy Carve-Out Prior to 1998, health plans in New York's Medicaid program covered pharmacy benefits. Pharmacists complained, however, that the reimbursement paid by the plans was well below the state's fee-for-service rates. The pharmacists then convinced the state legislature to carve out the pharmacy benefit, preserving their higher fee-for-service reimbursement rate. New York is now one of about ten states with a pharmacy carve-out for its traditional Medicaid managed care program—although, notably, the pharmacy benefit is included in Family Health Plus, which was first implemented in 2001.¹²

For several years, political support in favor of the carve-out remained strong. Consumer advocates and health care providers preferred broad fee-for-service coverage to narrower (and varied) health plan formularies. Health plans appreciated the financial benefit of freedom from rising pharmacy prices and higher pharmacy utilization rates. State budget officials noted that the state was partially shielded from rising pharmacy costs because of a federal law requiring pharmaceutical manufacturers to provide a significant rebate on drugs purchased in the fee-for-service market. The federal rebate, which varies according to the mix and volume of drugs purchased in each state, provided New York with a 23 percent discount on outpatient prescription drugs in 2006.¹³ The state realizes additional rebates on directly purchased drugs that are on its preferred drug list—savings that are not realized by managed care plans.

Over the last couple of years, however, the pharmacy carve-out has become increasingly controversial. Consumer advocates note that the state's preferred drug list is looking more and more like health plans' formularies. Policy analysts point out that pharmacy is not carved out of other state public insurance programs (such as the State Children's Health Insurance Program). Health plan medical directors complain that the carve-out undermines efforts to provide coordinated care; while the state does pass along pharmacy utilization data on plan members, the directors complain about both the quality of the data and the time lag in transmission.

Nonetheless, in 2006 the state legislature renewed the carve-out, largely because of a perception that the savings generated by the rebate exceed savings likely to be generated by the imposition of health plan formularies. A recent study challenges this assumption, suggesting that moving drugs back into the Medicaid managed care benefit package may save more than the state rebate (Lewin 2004).

Behavioral Health Health plans have always provided basic mental health services (often via subcontract) to all Medicaid enrollees other than SSI beneficiaries. Until recently, the carve-out has generated little controversy, both because most severely mentally ill persons are exempt from managed care altogether, and because few health plans contract with the community-based mental health providers that serve this population. Indeed, the state Office of Mental Health has long supported the carve-out as in the interest of both patients and community-based providers.

¹³ United Hospital Fund analysis of CMS Form 64.

The issue is becoming increasingly controversial, however, given the recent decision to remove the managed care exemption of New York City's SSI beneficiaries with severe and persistent mental illness. To be sure, the carve-out means that these beneficiaries will continue to receive behavioral health services from their longstanding providers. Nonetheless, analysts and advocates are concerned, albeit for different reasons. Some worry that the new rules will undermine relationships between beneficiaries and their long-time behavioral health providers. Because beneficiaries often receive physical health care and behavioral health care at the same clinic, a change of physical care provider could lead to a change of behavioral health provider as well. Those who support the carve-out—and distrust the adequacy of health plan networks—thus suggest that moving these beneficiaries into managed care could be problematic. Conversely, health plan officials worry that the carve-out will undermine their ability to oversee and coordinate the care of a needy population, especially since the psychiatrist often serves as the de facto primary care physician for the severely mentally ill.

Medicaid officials acknowledge their uncertainty about the best model to serve populations with complex medical and mental health needs; a state health department workgroup is now considering the issue. Health plan officials also express a broad range of views. Indeed, because of conflicts on the issue among its members, the Coalition of Prepaid Health Services Plans has declined to take a position. Providers and consumer advocates are equally divided.

Policy Summary: Benefit Carve-Outs In New York, the decision to carve services out of the managed care benefit package is based on several factors, only one of which is the best interest of the beneficiary. The pharmacy carve-out, for example, was prompted by pharmacists' concerns over low health plan reimbursement. Similarly, the behavioral health carve-out was established in large part to protect community-based providers that were not part of traditional managed care networks.

Until recently, the impact of the carve-outs on beneficiaries was minimized by the decision to keep most medically complicated cases out of the managed care system. Over the next few years, however, the state expects to require more and more persons with complex medical and mental health needs to enroll in managed care. The mandatory enrollment of SSI beneficiaries in New York City is the beginning of this trend. So far the policy requires such beneficiaries to receive medical care from a managed care plan and behavioral health care from the traditional fee-for-service system. With the current carve-outs in place, it is unclear how—or even whether—meaningful coordination of care can be achieved.

5. Should the State Regulate the Number of Health Plans?

New York State permits all health plans that meet basic financial and organizational requirements to participate in Medicaid managed care. Most counties with mandatory enrollment have between three and six health plans, but there are outliers at both ends of the spectrum: New York City, for example, with its seventeen plans,¹⁴ and Yates County, with only one. Throughout most of the state there is little controversy, then, about the number and mix of health plans. The debate generally focuses on the extremes of abundance and paucity.

Are There Too Many Plans in New York City? There are nearly 1.9 million Medicaid managed care enrollees in New York City, far more than the 600,000 or so enrolled in the rest of the state. Going purely by the numbers, therefore, it is not surprising that so many health plans are interested in participating there. It's a big market that can support a large number of health plans, especially when not all plans participate aggressively (or at all) in each of the five boroughs. In some neighborhoods, fewer than ten plans actively compete for enrollment. In addition, over the last ten to fifteen years, the number of participating health plans has fluctuated. In the late 1990s, for example, several commercial plans, such as Oxford and Aetna, exited the market following the imposition of a cost-cutting competitive bidding system. In the early 2000s, the number of new entrants rose, as health plans returned to profitability. More recently, the market has seen a mild consolidation, with several mergers and plan affiliations.¹⁵ The top four plans now serve 53 percent of the city's managed care enrollees, and the top eight plans serve 77 percent.

At the same time, consumer advocates, health care providers, state officials, and the larger health plans all favor a reduction in the number of participating plans. Consumer advocates argue that beneficiaries must choose from a bewildering array of health plans, nearly all of which have overlapping provider networks. These advocates suggest that the plan selection process is too often confusing, frustrating, and essentially meaningless, since most beneficiaries will be cared for by the same clinic or hospital regardless of plan choice. Health care providers also complain about the large number of health plans, and the need that creates to join multiple networks, submit reams of duplicative paperwork, and follow slightly different referral procedures for each. State officials point to the high administrative costs of regulating such a crowded market, the dollars spent by plans in an effort to build (or even maintain) market share, and the difficulty of identifying and rewarding good performance in such a complex environment. Finally, the plans themselves complain that the large number of competitors leads to fierce and expensive marketing, while overlapping provider networks make it hard to exercise real leverage over providers.

¹⁴ Since March 2007, one of those plans, Community Premier Plus, has ceased operations.

¹⁵ GHI merged with HIP; Partners in Health (St. Barnabas) ceased operations and its owner became a joint sponsor of HealthFirst, which is affiliated with Managed Health, Inc.; United Healthcare bought Americhoice; Fidelis Care bought CenterCare. All operating plans are listed separately on State Department of Health health plan enrollment reports.

New York City Medicaid Managed Care Enrollment (thousands), March 2007

Health Plan	Enrollment	Share	MMC	FHP
HealthFirst PHSP	319	17%	253	66
MetroPlus Health Plan	233	13%	194	40
HealthPlus	230	12%	185	45
Health Insurance Plan of Greater New York	205	11%	162	43
Affinity Health Plan	139	8%	105	35
Americhoice of New York	110	6%	94	16
Amerigroup (formerly Careplus)	106	6%	77	29
New York State Catholic Health Plan (Fidelis Care)	94	5%	79	15
Neighborhood Health Providers	84	5%	69	16
Wellcare of New York	79	4%	51	28
Community Premier Plus	73	4%	64	9
CenterCare	64	3%	54	10
NewYork-Presbyterian Community Health Plan	58	3%	46	12
United Healthcare Plan of NY	45	2%	31	14
GHI HMO Select	11	1%	9	2
Community Choice Health Plan of Westchester	4	0%	3	1
Managed Health Inc./A+ Health Plan	2	0%	2	0
Total (all plans)	1,858	100%	1,478	380

Note: Since March 2007, Community Premier Plus has ceased operations. Special Needs Plans (SNPs), which account for about 2,000 enrollees, are not included. Figures may not sum to totals due to rounding. MMC = Medicaid Managed Care FHP = Family Health Plus

There is no consensus, however, on how best to achieve a consolidated market. One option would be for the state to determine the optimum number of health plans and then institute a system of competitive bidding designed to reach that goal. Little support exists for this approach, especially among those who participated in the unsuccessful competitive bidding experiment of the mid-1990s. Indeed, as discussed elsewhere in this report, the state is just beginning to phase in a new health plan rate-setting system, and it is extremely doubtful it would abandon that effort at this point and return to competitive bidding.

The state also could enact administrative rules that would make it more difficult for smaller health plans to compete. In 2005, for example, the state began phasing in an increase in required financial reserves. Shortly thereafter, it capped the administrative portion of health plan premium payments at \$25 per member per month (and \$34 per person for Family Health Plus enrollees), although health plans can spend more per member on administrative costs. As noted earlier, state officials also recently capped the number of facilitated enrollers plans can have. Each of these changes makes it harder for small plans to compete, at least in markets (like New York City) dominated by several large (and financially successful) plans. Under this scenario, the recent trend toward consolidation will continue, although the state would do little to explicitly steer the outcome.

In considering the consolidation issue, state officials also need to think about the mix of health plans. Three of the four largest plans in the current market are hospital-sponsored PHSPs (HealthFirst, HealthPlus, and MetroPlus). The other plan in the top tier is HIP, one of the few plans in the city that markets in both the public insurance and employer-sponsored markets. The second tier includes more hospital-owned plans, as well as plans owned by community health centers and several others that are not provider-owned. Is this the right mix of plans? Should state officials let the market determine the mix of winners and losers? Or do certain types of plans deserve special protection? In prior years, for example, state policy favored PHSPs,¹⁶ giving them an advantage in the formula that assigned beneficiaries who did not voluntarily select a health plan. PHSPs also had less rigorous financial reserve requirements to meet. More recently, however, the state changed both rules to level the competition between PHSPs and HMOs.¹⁷

Looking forward, state officials insist that far more important than the organizational structure of a plan is its performance on state-administered quality report cards. It is the high-scoring health plans that now get preference in the auto-assignment process. High-scoring plans also receive a significant fiscal bonus (discussed later in this report). It seems likely, therefore, that to the extent the state explicitly steers the consolidation of the New York City market, it will do so by favoring those health plans that score well on quality-of-care indicators.

Are There Too Few Plans in Some Upstate Communities? Among the forty-two counties with mandatory managed care, as of September 2007, eleven have two participating health plans and three have only one.¹⁸ While there is some concern about the adequacy of the managed care option in these counties, there is no evidence that suggests that Medicaid managed care cannot work effectively with only one or two health plans. In California, for example, most Medicaid beneficiaries either are required to join a single plan (such as the Health Plan of San Mateo) or have a choice of two (one county-sponsored and one private-sector). Moreover, several states do not contract with any health plans, preferring a government-run primary care case management program, in which Medicaid officials themselves act as the managed care administrators.

¹⁶ Following the exit of several traditional commercial plans in the mid-1990s, state officials decided to provide special protection for PHSPs. The goal was to ensure that these provider-sponsored plans remained financially viable.

¹⁷ The Executive Budget for state fiscal year 2008-2009 proposes extending a tax of 1.75 percent of premium revenue, which now applies to commercial accident and health insurers, to for-profit HMOs. This would replace the existing tax, which is based on HMOs' income.

¹⁸ The eleven counties with two health plans are Allegany, Cortland, Fulton, Genesee, Livingston, Montgomery, Ontario, Putnam, Saratoga, Sullivan, and Washington. The counties with one plan are Otsego, Seneca, and Yates. Monroe County added a third plan between March and September 2007.

Monroe County, New York, is a textbook case of a thriving managed care initiative with—until shortly after March 2007—just two participating health plans. The dominant plan in the market is the Monroe Plan, which had enrolled roughly 51,000 of the county’s 67,000 managed care beneficiaries. The other 16,000 were enrolled in Preferred Care. Both plans are considered quality-of-care leaders. Preferred Care was the top-ranking plan in the state’s 2006 quality report card and the Monroe Plan ranked third. State officials, consumer advocates, and policy analysts all speak highly of both plans, and no one suggests a need for more plan competition.

Monroe County Medicaid Managed Care Enrollment, March 2007				
Health Plan	Enrollment	Share	MMC	FHP
Excellus (Monroe Plan for Medical Care)	50,925	76%	41,897	9,028
Rochester Area HMO/Preferred Care	15,647	24%	15,647	0
Total (all plans)	66,572	100%	57,544	9,028
Note: MMC = Medicaid Managed Care FHP = Family Health Plus				

One explanation for the success of the Monroe County initiative is the longstanding acceptance of managed care in Rochester, the county’s largest city. The private sector in Rochester was an early and enthusiastic supporter of managed care, and this culture seems embedded in the local health care marketplace, including those primary care practices that have large Medicaid enrollments. Moreover, unlike the Medicaid clinics in New York City, which likely have contracts with a dozen or more health plans, none with enough of its own members to exert real leverage, the two Monroe County plans (and especially the Monroe Plan) still have tremendous leverage over their network providers, which they utilize when implementing disease management and other care management initiatives. The lack of health plan competition in Monroe County may thus, ironically, be one reason for the success of the county’s managed care initiative.

There is no guarantee, however, that other upstate counties with little health plan competition can replicate Monroe’s success, especially counties that are largely rural, with resistant provider communities. The task in these more rural counties, however, may not be to lure additional health plans to the local Medicaid market, but may instead be to inculcate among providers, beneficiaries, and advocates more of an acceptance of the principles of managed care.

Policy Summary: Regulating the Number of Health Plans The Medicaid managed care market in New York City is crowded with health plans fiercely competing—in large part—for each other’s current or recent Medicaid enrollees. Consumer advocates, health care providers, state officials, and the large plans all favor a reduction in the number of health plans. In contrast, fourteen upstate counties have only one or two participating health plans, and another twelve counties are without any participating health plans at all. In New York City, the issue is whether the state should aggressively try to steer a market consolidation, either through a system of competitive bidding or through a more regulatory approach, and, if so, what criteria should guide state policy. In more rural communities, in contrast, the question is whether the state should push ahead with a traditional capitated managed care model even where there is little health plan competition, or should instead move toward a system of primary care case management.

6. Does State Reporting of Quality Indicators Improve Health Plan Performance?

The goal of Medicaid managed care is to provide beneficiaries with better care at lower cost. The assumption is that health plans will provide clients with a medical home and will coordinate and manage their health care use. In a recent summary of the literature, however, one analyst points out that there is surprisingly little national evidence that Medicaid beneficiaries do better in managed care than in traditional fee-for-service programs (Spitz 2007). Some studies even suggest that Medicaid HMO beneficiaries can have more limited access than their fee-for-service counterparts (Kaiser 2001).

In New York, however, Medicaid officials point to their health plan quality assurance reporting requirements for evidence that Medicaid managed care beneficiaries not only have better access and better care than those in fee-for-service but also are significantly better off than Medicaid managed care beneficiaries elsewhere. The linchpin to this argument is the state’s Quality Assurance Reporting Requirements, known as the QARR system, through which the state measures and compares health plan performance in both the commercial and Medicaid markets. The variables measured change annually, but are generally drawn from indicators generated by the National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS), as well as beneficiary satisfaction surveys. The state then publishes the results, and also provides various rewards to high-scoring plans (including a significant fiscal bonus).

The 2006 QARR measured health plan performance on specific criteria in the areas of child and adolescent health, women's health, behavioral health, and management of chronic illness in adults, along with providing more general reviews of provider networks and member satisfaction. The results suggest that, on balance, health plans in New York's Medicaid market score higher than their counterparts elsewhere in the country (New York Coalition of Prepaid Health Services Plans 2007). State officials have also used prior-year results to compare access to care for Medicaid managed care clients and those still in fee-for-service. Here, too, the rates on almost all indicators (such as immunizations and preventive health screenings) were higher among managed care enrollees (Roohan et al. 2006).

Not surprisingly, there is also wide variation in health plan QARR scores. In 2006, for example, the highest-scoring plan was Preferred Care, with 126 total points; CenterCare, in contrast, was at the bottom of the list with just 24 points. Other high scorers included MVP Health Plan (119 points), the Monroe Plan (113 points), and Hudson Health Plan (112 points). Other low scorers were NewYork-Presbyterian Community Health Plan (47 points), Community Choice Health Plan of Westchester (50 points), and GHI (56 points).

The 2006 report suggests two intriguing patterns. First, the top-scoring plans were all based upstate (although several New York City-based plans, such as Fidelis Care and MetroPlus, also did well). Second, several of the lowest-scoring plans have recently been bought by or merged into some other plan. There is no evidence, however, that organizational or ownership status makes a difference: there were non-profit provider-sponsored plans and for-profit HMOs at both the top and bottom of the list.

State officials suggest that the scores—especially the gaps between the high- and low-scoring plans—reflect important differences in access and quality. They concede, however, that the results are less useful for assessing the health plans bunched together in the middle, but insist that the rankings (and the various rewards that accompany the results) encourage plans to engage in numerous quality improvement activities.

Health plan officials (at both high- and low-scoring plans) are more skeptical of the reliability of the QARR scores. One commonly heard complaint is that the scores reflect plan data collection capacity more than actual quality outcomes. The argument is that some providers (particularly large and busy clinics) do a poor job of submitting client encounter data, especially if they are paid on a capitation basis, and that because an immunization, for example, isn't reported does not mean it was not delivered. Another complaint is that high rates of enrollment churning undermine the utility of the results, since many of the variables track outcomes over fairly long time periods and, by definition, don't count the large share of enrollees who churn out of coverage. Finally, by ranking health plans the state presumably encourages a competitive marketplace, but one in which there is a competitive disadvantage to sharing data and best practices. Some health plan officials say the state should instead encourage more cross-plan quality improvement efforts, but that such an approach is unlikely to succeed as long as QARR is so important.

State officials agree that the QARR scores are an imperfect and incomplete measure of quality. Nonetheless, they point out that collecting good data is the first step to nearly any quality improvement initiative, and that state programs that prompt improved data collection efforts will inevitably lead to improved quality. Indeed, the primary target audience of the QARR reports is the plans themselves, and the goal is to prompt low-scoring plans to seek improvement (both in data collection and in actual outcomes). Encouraging this sort of competitive market is therefore good, and need not necessarily undermine supplemental efforts to promote occasional cross-plan quality improvement programs. State officials also note that while enrollment churning means some managed care beneficiaries are not included in the QARR reports, more than 50 percent of beneficiaries are. The population captured is therefore still significant enough to be useful, officials claim.

Policy Summary: State Reporting of Health Plan Indicators The QARR system is the most important element of the state's effort to evaluate and regulate the managed care initiative. State officials point to QARR scores to show that beneficiaries in managed care do better than their fee-for-service counterparts. State officials also rely on QARR scores to rank and reward health plan performance. Health plans, in turn, expend tremendous resources in an effort to do well on the QARR scorecard. Despite their pivotal role, however, there is still much uncertainty over the reliability of the QARR scores (especially for plans bunched in the middle of the pack), the extent to which QARR is a tool for quality improvement, the utility of the QARR system to evaluate care rendered to beneficiaries such as the severely and persistently mentally ill, much of whose care is carved out of the managed care benefit package, and the extent to which QARR should be used to reward (or punish) plan performance.

7. How Will Health Plans Respond to the State's New Rate-setting System?

Prior to the mid-1990s, New York paid relatively generous capitation rates to participating health plans (Sparer 1996). The high rates were due to two factors. First, rates were based on fee-for-service costs, and such costs in New York were quite high. Second, rates were set via direct negotiations between state officials and health plan managers, and the state used this process to lure commercial HMOs (such as Aetna and Oxford) into the market while also allowing high-cost hospital-sponsored health plans to prosper. The high capitation rates did, indeed, produce a crowded health plan marketplace (at least in New York City), but the system of individual negotiations was also inefficient and administratively costly.

In 1995, as state officials prepared to phase in mandatory managed care, they also decided to abandon negotiated rates in favor of a system of competitive bidding. The goal was to have fewer plans, and a more cost-efficient program. By all accounts, however, the competitive bidding process soon turned into a political and programmatic nightmare. State officials encouraged—indeed required—cost savings by declaring that bids above certain rate bands would be rejected. After the bids were in, however, the state decided to keep all bidders in the market (thereby ending the effort to reduce the number of participating plans), and offered those above the rate band maximum a take-it-or-leave-it final offer, which the health plans grudgingly accepted. The political controversy over the double-digit rate cuts soon led the state legislature to impose a modest rate increase, although the health plans continued to complain that they were losing money on the program. Several of the commercial plans then decided to leave the market (Sparer, Brown, and Kovner 1999).

The state ended its experiment with competitive bidding in 1999, and again began to negotiate plan-specific capitation rates. Under this system, health plans supply the state with data about members and expenditures during the previous rate period, along with a proposed new rate based on forecasts about utilization and costs. Plans supply separate filings for each region in which they compete, as well as for ten distinct actuarial groups. The state then reviews the data and offers the plan a new set of rates going forward. The two sets of negotiators meet, wrangle over the estimated medical expenses, and reach an agreement. The new rate covers a one-year time period, but rather than repeat the process annually the state typically provides a standard inflation-bump for the second year, before beginning the process over again. In addition, the state also provides a quality bonus of up to 3 percent of the rate, based primarily on QARR performance.

State officials believe that the health plans have generally done well in the negotiation process, and that most of the plans are in a good financial position. These officials acknowledge that there are years when plans go without expected rate increases: in 2005, for example, state regulators imposed a one-year rate freeze, and in 2007 the state legislature did the same. The regulators note, however, that negotiated rate increases in 2006 were higher than usual (9 percent on average), in large part to compensate for the rate freeze the prior year.

At the same time, the evidence suggests that New York's capitation rates are not, by national standards, particularly high. According to one study, for example, New York's 1998 rates were well below the national average (Holahan and Suzuki 2003). This is, perhaps, not surprising, given the competitive bidding process then underway. Nonetheless, while the state had the third-fastest-rising rates between 1998 and 2001, rates overall still remained comparatively low (Holahan and Suzuki 2003).

While careful not to release proprietary information, most health plan officials acknowledge that their plans have done well financially in recent years. This is especially so for those plans that keep administrative expenses relatively low, and that negotiate good deals with providers (especially hospitals and other institutional providers). To be sure, the plans collectively complain about the intermittent rate freezes, especially when, as in 2007, the legislature simultaneously increased the rate the state pays for inpatient hospital care. This change is problematic for those plans that use the state rate as the basis for their hospital contracts. This development also concerns hospitals, which worry that the plans will try to renegotiate rates and/or increase care denials. Health plans also worry that their competitors have political or other advantages in the rate-setting negotiation process, resulting in unfair variation in rates and in unjustified gaps between the fortunes of those plans that are profitable and those that are not.

State officials are also troubled by the spread in health plan rates, as well as by the significant administrative burden imposed by the individual negotiation process. These officials point out that the negotiation process gives health plans an incentive to spend more (in order to get more). This is considered especially problematic for provider-sponsored plans, which have little incentive to lower provider rates and great incentive to keep such payments high. For all of these reasons, in 2006 the state began work toward a fundamentally different rate-setting system, one that will be phased in beginning in 2008.

The goals of the new rate-setting system are to standardize the process, to make rates more equitable, and to ensure that rates are risk-adjusted. Under the new system, the state will calculate the average costs for health plans in nine regions across five broad groups of beneficiaries. The state will then increase or decrease that average cost (or rate) for each plan based on its members' health status, which will be determined by placing the members into "clinical risk groups," or CRGs (Hughes et al. 2004). The state also will adjust rates to reflect optional benefits provided by each plan. Rates will thus be based primarily on patient characteristics and services delivered, rather than on what particular health plans pay particular providers.

When, in 2008, the state begins to phase in the new system, 25 percent of the capitation rate will be based on CRGs and 75 percent will be based on the prior-year rate. Over the following three years, the percentage based on CRGs will increase annually, so that by 2011 the rate will be fully risk-adjusted.

Neither the state nor the health plans can predict the impact of the new rate-setting system, in part because no other state has implemented a Medicaid CRG program. While other states (as well as the Medicare program) do risk-adjust rates, the relevance of those programs to the New York effort is not clear. Uncertainty stems, as well, from the increased importance of beneficiary utilization data. There is great variability in the extent to which health plans successfully collect such data, but the new system will clearly reward those plans that do the best data collection job. As a result, several health plans are already changing the way they pay primary care providers, switching from capitation to fee-for-service, simply because providers are more likely to submit good data if they are paid separately for every patient encounter rather than on a capitated basis.

A number of efforts are underway to predict which health plans will do better under the new system, which will do worse, and how all can improve their prospects. Several plans are pessimistic about how they will fare, either because they have poor data to document services for their high-cost clients or because they have done well in individual negotiations and presumably will fare poorly in a system that begins with regional rates. Other plans are more optimistic, either because they will be helped by the regional norms or because they can clearly document their high-cost cases. Regardless of these preliminary predictions, however, it is clear that the new system will fundamentally change the rate-setting process in ways that are uncertain and will have significant consequences.

Policy Summary: Setting Managed Care Rates Beginning in 2008, the state will phase in a new methodology for paying health plans. Under the new system, the state will calculate the average costs for health plans in nine regions, and then adjust that cost (or rate) for each health plan based on the health status of the plan's members. The new system is dramatically different from the current one, under which state and health plan officials negotiate rates based solely on prior and expected costs. Neither the state nor the health plans can easily predict the impact of the new system, although one short-term effect is that several plans are changing the way they pay primary care providers—moving from capitation to fee-for-service—in an effort to improve utilization data collection.

8. What Strategies do Health Plans Use to Improve the Care Delivery System?

Before the rise of the managed care movement, there was a clear bifurcation between provider and payer: the provider delivered care and the payer paid the bill and only rarely did the payer challenge the provider's decision-making or autonomy. This system led to at least three problems: sharply rising health care costs, the wide variation in physician practice patterns known as "small-area variation," and duplicative and uncoordinated care. Managed care organizations promised to reverse each of these trends: capitation would eliminate the fiscal incentive to provide unnecessary care, practice guidelines would limit small-area variation, and primary care gatekeepers would ensure that patient care was managed and coordinated. Each of these changes, however, represented a challenge to provider autonomy and income and prompted a strong backlash among both providers and their patients. Perhaps not surprisingly, managed care organizations—many of which are owned by providers—changed course, scaling back capitation, making practice guidelines purely advisory, and, most importantly, minimizing efforts to challenge physician autonomy.

Managed care organizations, and the payers that hire them, nonetheless remain eager to reform and improve the health care delivery system, especially where, as in New York State, that system is geared towards expensive hospital-based care. Indeed, New York adopted its Medicaid managed care initiative largely based on the premise that managed care could reorganize and improve the care delivery system for the poor.

Health plans in New York's Medicaid market employ two main strategies in their efforts to improve the care delivery system. First, they profile providers, to determine compliance with quality standards and develop targeted plans for quality improvement. Second, they establish disease and care management programs, aimed primarily at encouraging members to make and keep medical appointments, take all required medications, and follow dietary restrictions. Health plans are also cautiously experimenting with pay-for-performance programs, designed to financially reward providers who deliver high-quality care.

Provider Profiling Health plans generally send quality performance reports to network providers with significant numbers of plan enrollees, to let them know whether they are meeting the goals surveyed in the QARR reports. Have children assigned to them received their scheduled immunizations? Have adults received preventive screenings? How long do members wait for appointments? Are members satisfied with their care? How do the providers compare on all these measures with their counterparts elsewhere?

While some plans use the reports as part of a pay-for-performance program, far more common is use of the data simply as a conversation-starter, to point out patterns and seek explanations. Why are providers ordering more MRIs, for example, than those in an adjacent area? Why the low score on breast cancer screening? Or the low rate of timely prenatal care? Does the practice need to reorganize its appointment scheduling system? Convert to electronic medical records? Hire a new nurse practitioner? Are there best practices in some provider offices that should be shared with colleagues? What other lessons are suggested by the data?

At the Monroe Plan, for example, the provider relations staff meets regularly with the plan's sixteen largest provider offices, and at least annually with all primary care providers with twenty-five or more members. In New York City, MetroPlus develops more than 300 reports for medical directors in various offices. HIP sends reports to PCPs every quarter and seeks corrective action plans when performance falls short. Affinity Health Plan e-mails reports to large practices on a monthly basis.

The extent to which profiling efforts influence provider practice patterns seems to depend on two factors. First, what percentage of the provider's or clinic's patient population is enrolled in a particular plan? The higher the percentage, the more leverage the plan has. In Rochester, for example, the majority of patients at several large clinics are enrolled in the Monroe Plan, which gives the plan's medical director unusual influence over provider behavior. In New York City, in contrast, most community health centers have contracts with a dozen or more health plans, none of which has a majority of the center's patients, and none of which has much influence over practice patterns. Second, is the clinic's medical director receptive to the health plan data and suggestions? Even if the clinic's patients are predominantly in one health plan, some medical directors are resistant to health plan oversight, preferring instead to rely on their own profiling efforts.

Despite the occasional success story, the effectiveness of profiles so far seems quite limited. This is especially the case in New York City, where there are so many plans with so little leverage, and where few medical directors are responsive to plan outreach.

Providers also argue that a single profile—consolidating data on particular measures across all health plans—would be far more useful than the dozen or so reports they now get, indicating different measures, at different times, from different plans. Why not, for example, combine all their Medicaid enrollees with asthma in a single list, and produce a report that sets forth their total QARR scores regardless of plan affiliation? Providers also would prefer physician-based scores to the facility-level data they now receive, although they acknowledge that it is extremely difficult to gather such data in an environment in which interns and residents provide so much care.

The main obstacle to producing a report that consolidates provider data is health plan reluctance to share utilization data with competitors. In an initiative now underway in Rochester, however, the Finger Lakes Health Systems Agency is coordinating an effort to pool data from health plans (on Medicaid managed care enrollees) and from the state (on those still in fee-for-service), to develop provider profiles that look at quality indicators for all their Medicaid patients. At this point it is too soon to tell whether aggregating the Rochester provider data will work and, if it does, whether the model can be replicated elsewhere.

Pay for Performance Health plans in New York’s Medicaid market are cautiously experimenting with provider incentive programs, but are very reluctant to allocate much money to these initiatives. There are several concerns, the most important of which is skepticism as to whether the programs actually will encourage quality improvements. Here, again, the main issue is leverage. How large would an incentive have to be before it actually influenced provider behavior, especially when providers have contracts with multiple health plans? Nobody seems to know, although all agree that the programs now in place are too small and too decentralized to have much of an impact. Indeed, providers argue that they rarely know the criteria used in the various incentive programs, and that while they are pleased when a small bonus check arrives in the mail, it has no impact on their practice patterns or office procedures.

Nor is any health plan likely to dramatically expand its provider incentive programs any time soon. These days, plans are looking to cut costs, given the legislatively imposed 2007 rate freeze and the uncertainty of the impact of the new rate-setting formula. Plan leaders are likely to veto any new spending initiative unless it promises tangible benefits, and generally

do not believe provider incentive programs meet that test. At the same time, plans are also unlikely to eliminate programs already in place, mainly because those programs are a good marketing tool, and because there is some fear that there could be a provider backlash. Moreover, several plans that are skeptical of efforts to use provider profiles as a basis for bonus programs do have programs under which providers can apply for small quality improvement grants. The plans prefer this sort of grant program, since providers themselves clearly articulate how they will spend the additional funds and how those funds are likely to result in quality improvements.

Health plans are also likely to keep in place, and perhaps even expand, efforts to supplement primary care capitation payments with fee-for-service add-ons (or “bill-aboves”) for the delivery of targeted services. Several plans, for example, provide these supplemental payments for preventive services. From the plans’ perspective, the bill-aboves both encourage good preventive care and improve the documentation of such efforts, which is especially important as the state phases in the new rate-setting system. Given these benefits, those health plans that continue to capitate primary care are also likely to continue their reliance on the bill-above strategy.

Disease and Care Management Early proponents of managed care promised fixes to two longstanding health care problems: small-area variation, and the fragmentation and decentralization of the delivery system, in which doctors too rarely communicate with other providers to coordinate patient care. The solution to small-area variation was to translate the lessons of health services research into concrete practice guidelines, and to persuade (or require) network physicians to follow such protocols. The way to coordinate care was to require that enrollees had a primary care provider who would navigate the health care system on their behalf, serving as both a gatekeeper and an advocate. More recently, however, managed care organizations have acknowledged the obstacles to successful implementation of both strategies. Providers resist practice guidelines that feel imposed or that fail to offer flexibility for individualized decision-making. And consumers resist the bureaucratic requirements of gatekeepers and referrals, and pressure health plans to offer direct access to specialists.

The initial promise of managed care seemed especially potent in the New York Medicaid market. Under fee-for-service Medicaid, beneficiaries generally were unable to establish an ongoing relationship with a primary care provider, and instead sought care in community health centers, hospital emergency rooms, and hospital outpatient departments, rarely

seeing the same provider more than once. The system provided poor access to variable and uncoordinated care. The problems of small-area variation and a fragmented delivery system were ever-present.

The effort to use managed care to address these problems in the Medicaid market has encountered some of the same problems and obstacles seen in commercial markets. Nonetheless, Medicaid health plans continue to push initiatives designed both to standardize treatment protocols and to alter beneficiary utilization patterns. While provider profiling and pay-for-performance are part of this effort, the most common strategy is to expand so-called disease management or care management programs.

Medicaid health plans vary in the priority and resources given to their disease management initiatives. Some health plan CEOs are skeptical of their effectiveness while others believe they are central to ongoing plan success. The basic model, however, is relatively consistent across all plans, and incorporates four elements: first, identify enrollees with certain characteristics (e.g., asthmatics, diabetics, high-risk pregnancies); second, stratify them by severity; third, do some basic outreach to and education of the less severely ill, and prioritize case management resources for high-risk, high-cost members; and fourth, give physicians condition-specific practice protocols, but don't try to micromanage medical care.

One health plan, for example, notes that 80 percent of its disease management effort is targeted at encouraging members to make and keep medical appointments, take all required medications, and follow dietary restrictions. Most health plans also offer member incentives (such as gift certificates for prenatal care visits), twenty-four-hour nurse hotlines, and newsletters that provide health education tips and guidelines.

The plans are generally skeptical of efforts to change provider practice patterns, especially in an environment in which providers are asked to supplement their own approach with a host of slightly differing practice guidelines sent by health plans, medical specialty groups, and clinic medical directors. Over the course of a few months, pediatricians, for example, may well get more than a dozen asthma disease management protocols, most of which they'll ignore or use only to supplement their own practice styles. Moreover, since those asthmatic patients are likely divided among several health plans, there is rarely one particular plan with enough leverage to force doctors to comply with a particular approach. Physicians' practice patterns will thus be shaped primarily by their own experiences, supplemented by conversations with colleagues and their clinics' medical directors.

Plans also report significant frustration with disease management initiatives targeted at members. The biggest problem is the extent of clients moving on and off the rolls too often to be effectively managed. One health plan official noted that she is unable to reach 70-75 percent of a target population, largely because of this churning, although out-of-date addresses and unknown phone numbers are also common problems. There are also many clients who are simply unwilling to respond to and participate in a care management program. A recent state study documenting these issues found that, on average, plans could not contact 45 percent of their potential targets for case management (Gesten 2007).

Even with these limitations, some health plans report significant success in their disease management initiatives. The Monroe Plan, for example, implemented a program to reduce the number of low-birthweight babies. It first identified high-risk pregnant members by paying \$50 for every health assessment submitted by participating ob-gyn offices. It then aggressively directed follow-up care for those targeted patients. The result was a dramatic decline in the percentage of babies admitted to the neonatal intensive care unit, from 108 per 1,000 to 55 per 1,000, and an estimated savings of \$2.50 for every dollar spent on the program. The state's QARR reporting requirements encourage more such initiatives, by ranking health plans on a host of care management indicators, such as compliance with asthma medication protocols and follow-up visits following mental health hospitalization.

Still unanswered, however, is the more basic question of whether health plans ought to take the lead on disease management, or whether such efforts are better led by providers, the state, or even local governments. In New York City, for example, the Department of Health and Mental Hygiene has begun an effort to monitor the care of all diabetic residents, regardless of their insurance status or provider relationships (Fairchild and Alkon 2007). State officials are less inclined to conduct disease management initiatives themselves, especially when they have contracted with health plans to perform exactly that task. State leaders are also wary of micro-managing health plan efforts, since there are few obvious best practices. Should nurses or social workers take the lead in such programs? Should clients be called every six months or annually? What is the best strategy to encourage enrollees to follow prescription medication regimens? There are no clear answers. Given this uncertainty, the state's approach is to facilitate conversations on disease management strategies among health plans, providers, and beneficiaries, and simultaneously to reward those health plans that produce good QARR outcomes.

State officials are, however, considering an enhanced PCCM program for those beneficiaries still in fee-for-service Medicaid because there are no health plans in their communities or because they are exempt or excluded from the current managed care program. Under this model, now in place in sixteen other states, Medicaid pays primary care providers to serve as medical gatekeepers, but the state itself acts as the managed care plan, developing and supervising disease and care management programs. North Carolina, for example, is well-known for the innovative care management programs that are part of its PCCM program. Still, New York officials are extremely unlikely to adopt this model in any communities in which there are health plans willing to participate in Medicaid.

Those officials are more inclined to consider ways in which to house disease management programs in integrated provider delivery systems. An initiative along these lines would reflect the emerging view that basing such programs with providers themselves is optimal, and that government and health plans can play, at best, a supportive role. That this is the consensus among providers is hardly surprising, but more and more health plan medical directors have reached a similar conclusion. Part of the explanation is that health plans are frustrated by their inability to influence provider behavior, and thus less inclined to even try. More important, however, is a recognition that provider-sponsored disease management efforts are the most likely to succeed in changing both client behavior and provider practice patterns.

One possible model could build on efforts now underway at Montefiore Hospital to build an integrated delivery system covering nearly all of the Bronx, combined with a borough-wide health information system. The goal is to enable hospital officials to track and manage care received by any patient anywhere within the Montefiore system. The hospital already has capitation contracts with HealthFirst and HIP to manage the care of thousands of Medicaid enrollees, and hopes to enter similar arrangements with other plans. The assumption is that the system is large enough and sufficiently well-organized to truly manage care, much like an old-fashioned staff- or group-model HMO. Some early evidence supports that: data show that Montefiore's outpatient departments generate far lower per-patient costs than those of most other hospitals, mainly because they manage care effectively and reduce inpatient hospital stays (Billings and Mijanovich 2007). One option would be to expand the Montefiore model so that, within particular communities, there would be two to three large but separate integrated delivery systems, each aligned with a third-party-administrator health plan, each competing for Medicaid beneficiaries (Billings and Mijanovich 2007). State officials are impressed with the Montefiore model but uncertain whether it can be easily replicated.

Policy Summary: Strategies to Improve Quality Care Health plans utilize two main strategies in an effort to improve the care delivery system: profiling providers, to determine provider compliance with quality standards and to develop targeted plans for quality improvement, and establishing disease and care management programs, aimed primarily at encouraging members to make and keep medical appointments, take all required medications, and follow dietary restrictions. Health plans are also cautiously experimenting with pay-for-performance programs designed to financially reward providers who deliver high-quality care.

State officials have so far adopted a laissez-faire approach to these plan initiatives, focusing their regulatory oversight instead on overall health plan performance, as measured by QARR scores. As the managed care initiative moves forward, however, state officials might well need to adopt a more hands-on approach. One option is for the state to consolidate provider performance data across health plans and to push plans toward more aggressive adoption of a pay-for-performance approach. Given health plans' reservations about the impact they can have on care management, state officials also ought to consider playing a more active role in developing and implementing disease management protocols, perhaps working closely with providers, including integrated delivery systems where possible.

Conclusion: Has Medicaid Managed Care Been Successful?

The implementation of managed care promised to usher in a new era in New York's Medicaid program. Beneficiaries would have access to high-quality office-based medical care and would therefore reduce their reliance on expensive institutional care, especially emergency rooms. Health plans would establish disease and care management programs to ensure that diabetics, asthmatics, and other high-risk beneficiaries received appropriate and coordinated care. The state would supervise health plan performance and reward those plans that delivered high-quality, low-cost care. Medicaid would serve as the linchpin of an effort to improve the health care delivery system for low-income residents throughout the state.

How well has the Medicaid managed care program worked? By all accounts there are some impressive achievements. The program today is stable and well-entrenched throughout much of the state. As of March 2007, more than 2.5 million beneficiaries were enrolled in twenty-seven health plans. The state's QARR data demonstrate that these beneficiaries have better access to good care than do their fee-for-service counterparts in New York (New York Coalition of Prepaid Health Services Plans 2007). There are office-based primary care doctors who previously declined to treat fee-for-service beneficiaries who now serve those in managed care. Health plans encourage beneficiaries to receive basic preventive services, provide improved access to medical specialists, and often serve as advocates for a needy population. State regulators are far more proactive than when they were simply bill-payers in a fee-for-service model.

Health plans are also working hard to improve and expand beneficiary access. Until recently, for example, enrollees in hospital-sponsored PHSPs were nearly always assigned a hospital-based physician, whom they rarely actually saw, as their primary care provider. These plans have worked hard, however, to change this pattern. HealthFirst reports that 60 percent of its members have a community-based primary care provider. MetroPlus, Fidelis Care, and HealthPlus also report rapid expansion of their community-based networks (although each still remains hospital-dominated). Other plans have enacted novel programs to improve beneficiary access. The Monroe Plan, for example, recently implemented a program under which beneficiaries with an acute medical problem are guaranteed same-day appointments with their primary care provider. The "open access" initiative has reduced emergency room and hospital utilization among the plan's generally healthy enrollees.

State officials, as well, are aggressively managing the overall initiative, enacting a variety of new policies designed to expand Medicaid managed care's reach while simultaneously limiting overall spending. The decision to require mandatory managed care in fourteen new counties illustrates the policy of expanding the geographic scope of the program. The inclusion of New York City's SSI beneficiaries in managed care continues an incremental effort to reduce the number of exemptions and exclusions, as do managed long-term care demonstration pilots. The centralization of state oversight within the new Office of Health Insurance Plans demonstrates a commitment to reducing fragmentation and divided accountability. The new methodology for setting health plan rates will likely rationalize the rate-setting process and eliminate the ability of high-cost plans to continually negotiate high rates. The recent cap on the number of facilitated enrollers will likely reduce health plan marketing and administrative costs.

Even with these important improvements, however, there remains compelling evidence that the Medicaid managed care initiative has not achieved its underlying goals, and there is ongoing uncertainty over whether the state is pursuing the right managed care strategy:

- **It is hard to pinpoint exactly how the care delivery system for the poor has changed.**

Numerous beneficiaries still rely on hospital emergency rooms for primary care. Health plans are no longer permitted to pay a low triage rate for non-emergent care delivered in out-of-network emergency rooms (being required, instead, to pay the same state-determined rate for all out-of-network emergency-room care). Most beneficiaries still do not have an ongoing relationship with a primary care physician, regardless of the requirements and rhetoric of the program. Those beneficiaries who seek care in hospital outpatient departments are still treated primarily by medical residents, a trend especially prevalent in New York City's large academic medical centers. Comprehensive and coordinated oversight of episodes of care is still exceptionally rare.

- **An emerging consensus holds that health plans are in a relatively weak position to modify provider behavior.** By all accounts, the impact of provider profiling tools has been quite modest, especially when (as is most often the case) the percentage of the provider's or clinic's patient population enrolled in a particular plan is low. Similarly, few health plans have implemented pay-for-performance initiatives, nor are plans likely to expand such programs any time soon. Finally, many health plan officials now concede that the best place to house disease management programs is with providers themselves, and that plans (and government) can play at best a supportive role.

- **High levels of enrollment churning still limit care coordination, especially for the chronically ill.** Enrollment churning also complicates and undermines the state's effort to effectively monitor the quality of care, since many QARR variables track outcomes over relatively long periods of time and thus don't count those enrollees who churn out of coverage.

- **No independent evidence exists that the managed care initiative has lowered health care costs.** Part of the problem is that it is extraordinarily difficult to accurately compare managed care and fee-for-service spending. There are also various reasons to be suspicious of cost-cutting claims: health plans have high administrative (and marketing) costs, provider-sponsored plans have little leverage with which to cut the rates paid to their (often high-cost) sponsors, and the state imposes a variety of costly administrative requirements on plans. Even more telling is the extraordinary statistic that while 61 percent of Medicaid beneficiaries are enrolled in managed care, it accounts for only 14 percent of Medicaid spending, primarily because most elderly and disabled beneficiaries are excluded or exempt.

These conclusions raise difficult issues as the state moves ahead with its effort to establish care management systems for the disabled, the elderly, and the geographically isolated. It is unclear that moving these populations into traditional Medicaid managed care plans is wise policy. Plans may struggle to provide these beneficiaries with expanded access to high-quality and low-cost care, especially in a system in which major segments of care, such as behavioral health and pharmacy, are carved out of the managed care model. For these groups of beneficiaries, it may be better policy to move instead toward a primary care case management program or an integrated delivery system model.

In addition, while the state is unlikely to abandon health plan competition in communities, such as New York City, where the managed care delivery system for children and young adults is stable and well-entrenched, state officials should be asking whether and how health plans can do more to improve the care delivery system for the poor, whether and how health plans can have more of an impact on provider behavior, and whether and how health plans can actually lower costs.

This is a pivotal moment for New York's Medicaid managed care program. The state has moved 2.5 million beneficiaries into managed care, with relatively little controversy or complaint, but also with relatively little inquiry into the benefits for both beneficiaries and the government. State officials are now embarking on a much bigger and more controversial effort to expand managed care to more populations in all corners of the state. The promise of managed care remains clear, both for those now in the program and for those targeted for inclusion. The ongoing challenge, however, is to determine how to turn that promise into better care for all Medicaid beneficiaries.

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