

# **Medicaid Managed Care Reexamined**

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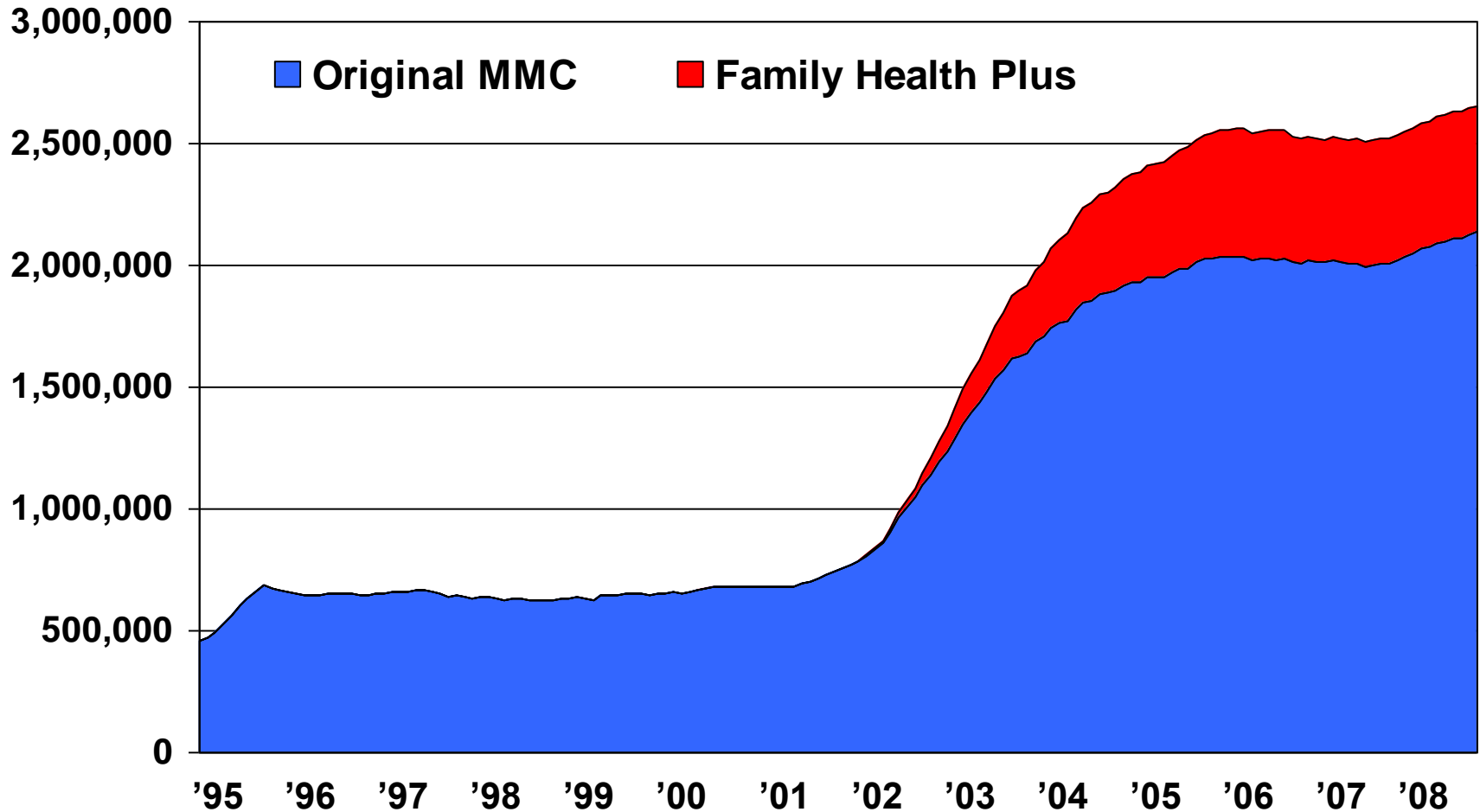
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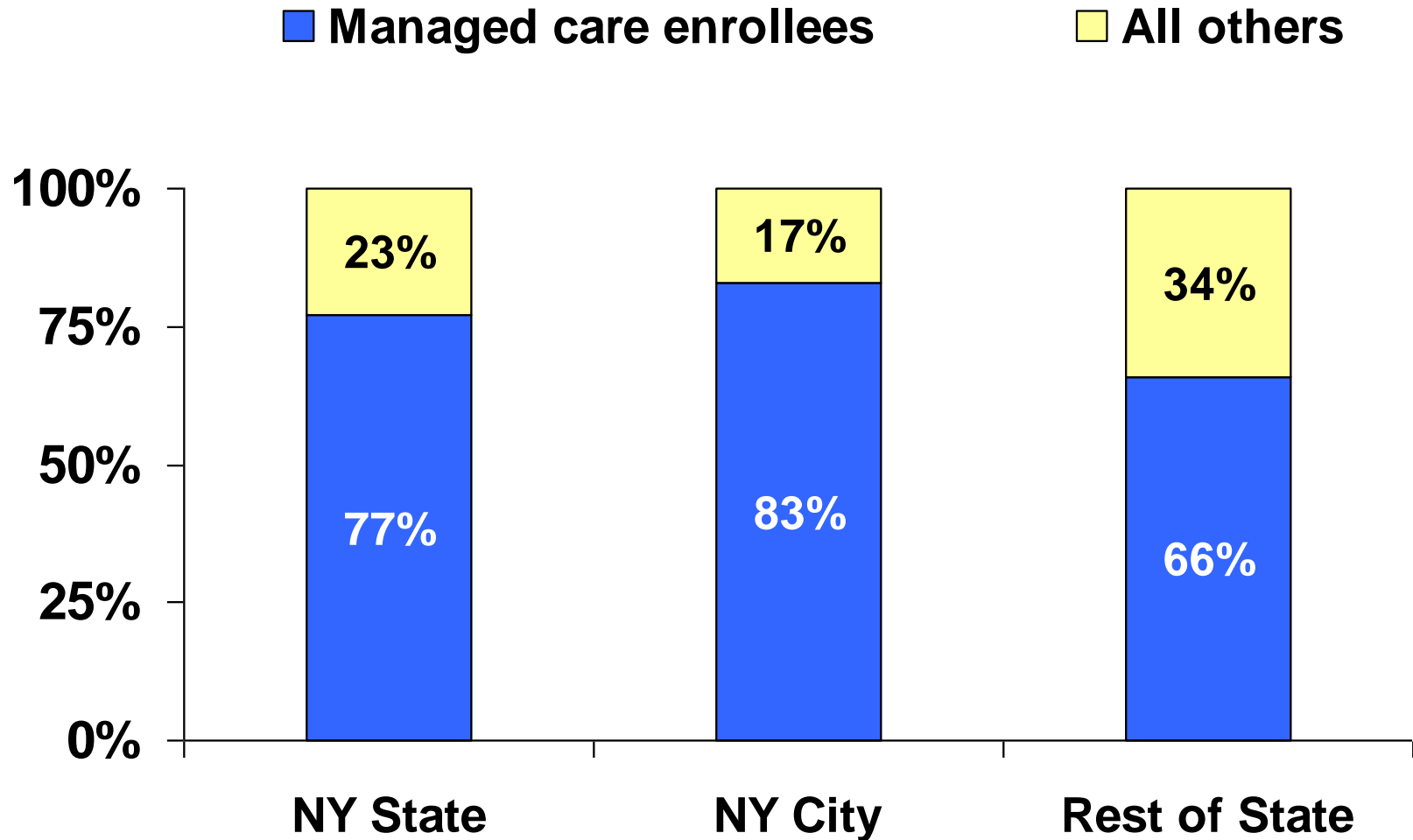
# Managed care enrollment within Medicaid: 1995 - 2008



Source: United Hospital Fund analysis of NYS Department of Health enrollment reports: January 1995 – April 2008.

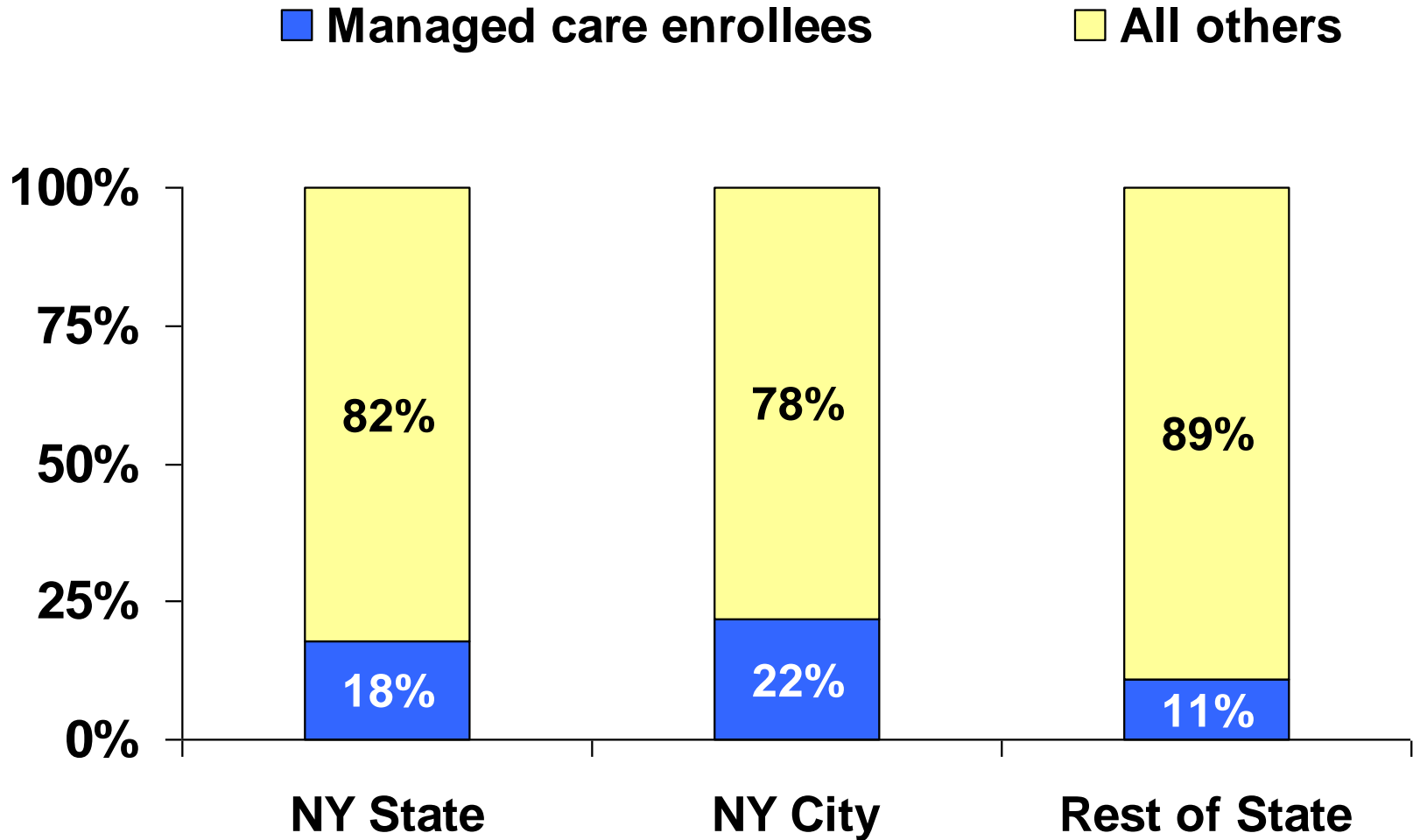


# Managed care penetration: adults and children

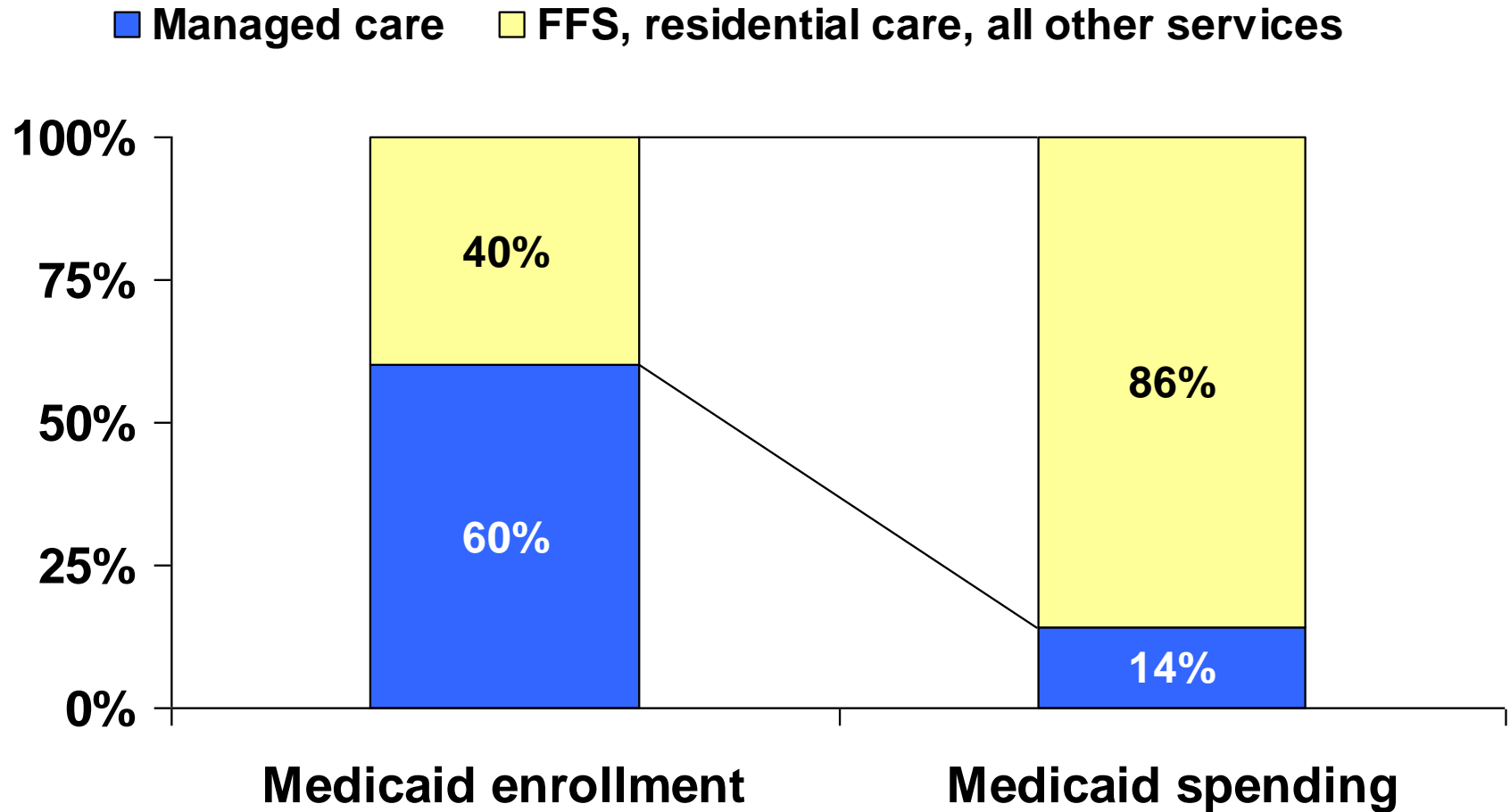


# **Managing care for beneficiaries with complex medical needs**

# Managed care penetration: elderly and disabled



# Managed care: 60% of enrollment and 14% of spending



**Note:** Medicaid spending is from FFY 2006. Enrollment is from September 2006.  
**Source:** UHF analysis of New York State Department of Health enrollment reports and CMS 64.

# State is requiring more beneficiaries to join managed care

- 11/05:** 125,000 SSI beneficiaries in NYC were mandated to enroll in MMC.
- 3/07:** Another 35,000 SSI beneficiaries with SPMI and SED in NYC were mandated to enroll in MMC.
- 11/07:** Five counties outside NYC begin mandatory enrollment for SSI beneficiaries.
- 11/08:** The State plans to have phased in mandatory enrollment for SSI beneficiaries in all counties that have a mandatory MMC program.

# Key services carved out of MMC

## All beneficiaries:

- Outpatient prescription drugs

## SSI beneficiaries:

- Outpatient mental health
- Inpatient mental health
  - Includes stays in general hospitals with MH diagnosis
- Outpatient substance abuse
- Inpatient substance abuse

**Note: One substance abuse service, detoxification, is carved-in for SSIs.**

# Key Questions

- Which exemptions and exclusions should be removed?
- Can meaningful coordination of care be achieved with the current carve-outs?
- Should the state establish a PCCM option for beneficiaries with complex medical needs?

**Is State oversight effective?**

# Quality Assurance Reporting Requirements (QARR)

- Results indicate that New York's Medicaid plans provide better care than the fee-for-service system and Medicaid plans in other states.
- Concerns that scores partially reflect data collection capacity rather than actual quality outcomes
- High rates of enrollment churning may undermine results.

# Rate-setting

## Old system: negotiated rates

- Each plan proposes new rate based on utilization and cost projections.
- State conducts individual negotiation with plan.

## New system: risk-adjusted rates

- State calculates regional average across five groups of beneficiaries.
- Each plan's rate is adjusted from regional average based on members' health status.

# Key Questions

- Is QARR an effective quality improvement tool?
- What will be the impact of the new rate-setting system?

**Has MMC improved the  
health care delivery system  
for the poor?**

# Are health plans able to modify provider behavior?

- Provider profiling: ability to impact physicians' practice is limited.
- Disease and care management: varying opinions over whether these programs are effective
- Pay-for-performance: plans are cautiously experimenting, but physicians report it has little influence on their practice patterns.

# Are beneficiaries less reliant on emergency room care?

- Plans are working to improve and expand beneficiary access, particularly to community-based providers.
- Beneficiaries still rely on the emergency room for primary care and rarely have ongoing relationship with a PCP.
- Comprehensive and coordinated oversight of episodes of care is still elusive.

# Conclusions

- Pivotal moment for New York's Medicaid managed care program
- Controversial state effort to expand MMC to more beneficiaries and to all corners of the state
- The promise of managed care remains clear, but the challenge is to figure out how to turn that promise into reality.