The United Hospital Fund's mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high quality, patient-centered health care services that are accessible to all. We undertake research and policy analysis to improve the financing and delivery of care in hospitals, clinics, nursing homes, and other care settings. We raise funds and give grants to examine emerging issues and stimulate innovative programs. And we work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change.
Medicaid Managed Care in New York: A Work in Progress

Kathryn Haslanger

United Hospital Fund
Contents

FOREWORD v
James R. Tallon, Jr.

ACKNOWLEDGMENTS vii

REAPPRAISING MEDICAID MANAGED CARE IN NEW YORK 1

THE FUND’S RESEARCH EFFORT 2

POLICY EVOLUTION IN NEW YORK 2

THE NUMBERS TODAY 5
Enrollment
Managed Care Plans

MANAGED CARE, COSTS, AND THE MEDICAL HOME 7

ACHIEVING THE GOALS 9
Program Design Features
A New Financial Model
Contractual Obligations

POLICY MEETS PRACTICE 10
Government Influence on Managed Care Plans
Plan Influence on Providers
Plan and Provider Influence on Enrollees

REAL-WORLD IMPACT 13
Access
Service Use
Quality
Cost

RECOMMENDED ACTIONS 21

REFERENCES 25
Foreword

In 1991, while still serving as majority leader of the New York State Assembly, I gave the keynote address at a United Hospital Fund conference, *Medicaid Managed Care: How Do We Get There from Here?*

A look back at the conference proceedings serves as a reminder of the genuine optimism, even idealism, that surrounded the planning of the program. Medicaid managed care may have been born out of the state’s harsh budget situation, but we set ambitious goals for improving access to health care and quality of care for Medicaid beneficiaries.

Twelve years later, it is fair to ask: Have we gotten there? This Special Report is an attempt to answer that question, as it measures what we have accomplished against the original program goals and points the way for future policy discussions.

Our analysis indicates that Medicaid managed care has had many positive effects. It has improved Medicaid beneficiaries’ access to primary care services and to community-based specialists, and it provides a framework for monitoring and improving quality of care. Less clearly demonstrated has been the program’s ability to change patterns of service use, yet its potential for shaping further improvement remains.

This report draws on more than a decade of analysis and research by the United Hospital Fund, in which we monitored the implementation of Medicaid managed care in New York City, analyzing its impact on more than one million enrolled New Yorkers and its effect on health plans and health care providers. We conducted interviews with policymakers, surveyed managed care plans and ambulatory care providers, analyzed Medicaid service claims, and hosted round-table discussions with government officials, industry leaders, and community advocates. We presented our research and analysis in special reports, working papers, journal articles, the *Medicaid Managed Care Enrollment Atlas*, and the quarterly *Medicaid Managed Care Currents*.

As part of this effort, we helped found the New York Consortium for Health Services Research in 1995. A collaboration with New York University’s Wagner School and Columbia University’s School of Public Health, the Consortium received support from The Commonwealth Fund, the Engelberg Foundation, the New York Community Trust, Pfizer Inc, and JP Morgan, for which we are most grateful.

The challenges that remain are daunting, the more so since New York State once again faces budget crises. The work of shaping managed care, and public health insurance, is not complete. This report underscores the need for public and private leadership to stabilize insurance coverage, redesign primary care, and rationalize the program’s regulatory and administrative relationships and requirements. The single most powerful lesson from our research is that changes in financing do not automatically translate into changes in service delivery. Managed care is an important tool, but its leverage alone cannot effect the fundamental overhaul of program eligibility and service delivery that is required.

As we grapple with the questions that lie before us, it is important to reaffirm our commitment to accessible, high-quality health care for all New Yorkers. For all its seeming arcana, health care policy is, after all, about how we care for one another.

JAMES R. TALLON, JR.
President
United Hospital Fund
Acknowledgments

Many people made important contributions to this report. With particular gratitude we thank the Medicaid Managed Care Project’s funders: The Commonwealth Fund, the Engelberg Foundation, the New York Community Trust, Pfizer Inc, and JP Morgan, as well as the United Hospital Fund.

The analyses summarized in this report represent the thoughtful work of many staff and consultants, past and present, at the United Hospital Fund and at our partner organizations, New York University and Columbia University. These analyses would not have been possible without the generous participation of government officials, managed care plans, ambulatory care providers, community advocates, and policy leaders — in surveys, roundtable discussions, conferences, and informal feedback sessions. We thank all participants for their time and willingness to share their experiences and insights as the program evolved. While their input contributed substantially to shaping our understanding of the issues, the findings we present and conclusions we have drawn reflect our own considered position, and final responsibility for this report lies with the Fund.
Reappraising Medicaid Managed Care in New York

In 2003, New York and most other states face fiscal crises, with deficits among all states expected to top $70 billion over the coming year. Medicaid spending is frequently cited as one of the culprits, and calls for Medicaid reform emanate from many quarters. Yet few analysts acknowledge that Medicaid has been “reformed” before: during the 1990s, most states converted major portions of their Medicaid programs from fee-for-service to managed care models. Proponents of Medicaid reform through managed care argued that it would control cost growth and create a “medical home,” offering Medicaid beneficiaries better and more consistent access to primary care and coordination of services.

What were the results of this earlier movement to reform Medicaid? Consumer and community advocates’ outcries, once intense, have more recently been fairly muted, so that one legislative leader in health policy remarked, “It must be working; I don’t hear anything.” Our review of Medicaid managed care in New York finds that, as in many other states, the program has made substantial strides but has not yet met policymakers’ far-reaching expectations of remedying low-income communities’ longstanding problems with obtaining quality health care.

Yet the question of how, and how much, managed care can address these persistent problems remains a critical one for New Yorkers. Over one million New York City Medicaid beneficiaries are already enrolled in managed care plans. In addition, policymakers selected this service model for two public insurance expansions: the Child Health Plus B program for children in families with income above the Medicaid cutoff, and the Family Health Plus Medicaid expansion for adults.* Discussions about Medicaid managed care policy directions thus have implications for all three of these public health insurance programs, not just traditional Medicaid.

Despite the complexities and challenges Medicaid managed care has introduced for providers, beneficiaries, and government policymakers, we have found no constituency in New York arguing for a return to the old fee-for-service program. The shortcomings of fee-for-service have been widely documented and discussed; there is very little nostalgia for the good old days. We did find a broadly based consensus among policymakers and advocates alike that the new “consumer driven” directions emerging as an alternative to managed care in commercial coverage are not an option for low-income populations. These initiatives involve levels of cost-sharing and financial risk that would pose real — and unacceptable — barriers to appropriate care for public program beneficiaries.

Our challenge, then, is to identify strategies for improving managed care in light of what we have learned about why its goals have been so difficult to achieve. To that end, this report

* Child Health Plus B was created in 1991 as an ambulatory care benefit program offered through managed care plans, and was expanded to offer comprehensive benefits on a fully capitated managed care model in 1997.
examines how policymakers sought to reshape service delivery and the influences that came into play as Medicaid managed care unfolded. We also assess the impact of the program in four key areas — access to ambulatory care, patterns of service use, quality of care, and cost containment or reduction — before proposing a number of policy and programmatic changes.

The Fund’s Research Effort

Our discussion draws on findings of a seven-year research and analysis project. In 1995, on the cusp of New York’s decision to seek federal approval to mandate managed care enrollment for over one million Medicaid beneficiaries, the United Hospital Fund collaborated with New York University’s Robert F. Wagner Graduate School of Public Service and Columbia University’s School of Public Health (now the Columbia University Mailman School of Public Health) to form the New York Consortium for Health Services Research.

We set out to assess the implementation of Medicaid managed care in New York City from four perspectives: those of policymakers, managed care plans, ambulatory care providers, and Medicaid beneficiaries. Our work included interviews with policymakers, surveys of managed care plans and providers, analyses of Medicaid service claims, reviews of other states’ experiences, and roundtable discussions with government officials, plan and provider industry leaders, and community advocates.

The New York Consortium for Health Services Research conducted this research, from its inception through 2002, with support from The Commonwealth Fund, the Engelberg Foundation, the New York Community Trust, Pfizer Inc, and JP Morgan, as well as the United Hospital Fund.

Policy Evolution in New York

We began our assessment of Medicaid managed care at what appeared to be a turning point in an evolving effort to remake New York’s Medicaid program. Managed care was not a new concept in 1995, but it certainly seemed to be picking up speed.

Like many states, New York had experimented with managed care during the 1980s. Its efforts were small in scale, and for the most part relied on Medicaid beneficiaries’ voluntary enrollment. By 1989, only two percent — 26,000 — of New York City’s beneficiaries had opted for managed care. A number of Prepaid Health Services Plans (PHSPs) had been formed specifically to participate in Medicaid managed care — many with the assistance of state grants — but enrollment was concentrated in the Health Insurance Plan of New York (HIP) health maintenance organization. HIP already covered many city employees and retirees; with its movement into Medicaid managed care, it gave Medicaid beneficiaries access to many physicians not otherwise available to them.

After making a series of difficult budget choices to close the revenue and spending gap in the state’s 1991-1992 budget, policymakers looked to an expansion of the managed care program as another cost-containment tool (LD Brown and Tallon, forthcoming). Passage of the Medicaid Managed Care Act established a goal of 50 percent managed care enrollment within five years. Counties were expected to step up efforts to promote voluntary enrollment, but the Act also authorized mandatory enrollment in counties where the 50 percent goal did not appear attainable on a voluntary basis. To ensure continued federal financial participation, this mandatory enrollment was contingent on a federal waiver of Medicaid’s freedom of choice provisions.*

* New York City began its Southwest Brooklyn mandatory enrollment demonstration project in October 1992. State authority for the demonstration project had been granted, at the city’s request, in 1988.
In 1992, state policymakers took another step toward accelerating managed care growth by applying pressure to commercial health maintenance organizations (HMOs). Unlike PHSPs designed to serve the Medicaid market, HMOs in most cases had to be persuaded to participate. Reluctant to mandate participation outright, the state passed legislation levying financial penalties on HMOs with Medicaid membership below a minimum percentage of total membership. As a result, commercial plans played a substantial role in New York City’s program, for a time.

Enrollment increased at a moderate but steady pace until 1995, when program dynamics changed dramatically. Between the spring and fall of 1995, enrollment in New York City jumped by over 40 percent, to a high of 451,514 in September. But this enrollment spike proved to be an aberration, not the first stage of rapid, sustained acceleration. Indeed, enrollment fell dramatically over the following year, then stabilized at between 380,000 and 400,000 between 1997 and 2001 (Figure 1). Policy changes had triggered market responses that in turn triggered policy corrections.

The critical policy change of 1995 was the state’s signal that it wanted rapid enrollment. Just a few months into Governor George Pataki’s first term, the state health department announced plans to request federal authorization of mandatory managed care enrollment for nearly all Medicaid beneficiaries. Managed care plans responded by stepping up marketing and enrollment activities, until widespread reports of marketing fraud and abuse led program officials, in September 1995, to suspend direct enrollment. The ban on health plans’ direct enrollment, which lasted one year, coincided with a decline in enrollment of more than 20 percent.

Two other policy shifts also contributed to falling enrollment. The first was the state’s new approach to plan contracts and rate-setting; the second was the city’s new administrative practices in its welfare offices.

In anticipation of the federal waiver allowing near-universal enrollment in Medicaid managed care, state officials revamped their process for contracting with plans and setting premiums. They envisioned a program with fewer plans participating, each with much larger enrollment. Fewer plans meant that

---

Figure 1: **Total Enrollment, Medicaid Managed Care, New York City, January 1993-February 2003**

![Graph showing enrollment trends from 1993 to 2003](source: United Hospital Fund analysis of New York State Department of Health enrollment reports)
strained government offices would find contract compliance and surveillance responsibilities easier to manage and that plans would be better positioned to exert bargaining power on Medicaid providers.

But despite a contentious procurement process and deep rate cuts, the expected market consolidation did not occur. Most commercial plans dropped out, but new provider-sponsored plans took their place. The Coalition of Prepaid Health Services Plans, an industry trade group, reported that premiums for plans in New York State were cut by 34 percent over three years; in 1997, premiums were lower than those paid to Medicaid plans in Connecticut and New Jersey (New York State Coalition 1997).

The other policy change affecting enrollment was not focused on managed care, or even on Medicaid. Instead, it applied to practices in New York City’s welfare centers. Even in advance of federal welfare reform, Mayor Rudolph Giuliani’s administration implemented what it called “front end diversion” to discourage new welfare applicants. Not only did cash assistance become harder to get; for those already receiving it, it also became harder to keep. City and state computer systems were not set up to seamlessly continue Medicaid coverage for those losing their cash grants, so plans faced high levels of involuntary disenrollment. In addition, there was a smaller pool of new Medicaid cases from which to recruit replacements (Toohey and Haslanger 2000).

Combined with a strong economy and, eventually, federal policy changes, the effect was a sharp decrease in the size of the eligibility group most likely to enroll in managed care: non-disabled families receiving cash assistance as well as Medicaid coverage. Between March 1995 and October 1998 this portion of the Medicaid caseload fell by 22 percent (Figure 2).

In July 1997 New York State received federal approval of its waiver request to mandate managed care enrollment for Medicaid beneficiaries. In New York City, each of four planned implementation phases would be allowed to proceed only after successful completion of a federal readiness review, designed to gauge the capacity of managed care plans and government agencies to handle large-scale enrollment. Mandatory enrollment began in Albany and four other upstate counties in October 1997, and was projected to begin in New York City in early 1998. But the city’s first phase did not begin until August 1999; the second phase began in April 2001.

---

**Figure 2:** AFDC Medicaid Enrollment, New York City, March 1995 and October 1998

<table>
<thead>
<tr>
<th># of Persons</th>
<th>March 1995</th>
<th>October 1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>944,329</td>
<td>728,283</td>
</tr>
<tr>
<td>Noncash</td>
<td>215,394</td>
<td>267,837</td>
</tr>
</tbody>
</table>

Source: New York State Department of Health, Office of Medicaid Management, Longitudinal Eligibility File
The Numbers Today

A snapshot of Medicaid managed care today — both beneficiaries and plans — shows some startling changes from the 1990s.

**ENROLLMENT.** In February 2003, over 1.4 million Medicaid beneficiaries were enrolled in managed care plans across New York State, over one million of them in New York City. After the slow pace of enrollment during the first two phases of the city’s implementation, most of this growth occurred during phases three and four: within the past two years, the city’s numbers skyrocketed nearly 150 percent. Contributing to this surge were the special enrollment provisions made in the city after September 11, to accommodate damage to the Medicaid computer system. A one-year suspension of recertification requirements for those receiving Medicaid without cash assistance resulted in plans’ loss of fewer members through involuntary disenrollment during this period than would normally be expected. Additionally, Disaster Relief Medicaid, a simplified application and enrollment process, added more than 340,000 New Yorkers to Medicaid’s fee-for-service rolls.

By early 2003, roughly 61 percent of the city’s Medicaid beneficiaries eligible to enroll in managed care had actually done so. In some upstate counties, where the mandate took effect five or more years ago, penetration exceeds 70 percent, a level that may be reached in New York City as full implementation approaches. These rates are misleading as measures of managed care’s importance to the health care delivery system, however. Nearly 650,000 New York City beneficiaries were either exempt or excluded from the managed care mandate and thus not counted as eligible to enroll. And, with New York embracing managed care for its other public health insurance programs as well, Medicaid comprises by far the largest but not the only portion of public managed care enrollment.*

As of December 2002, Child Health Plus B and Family Health Plus covered an additional 338,000 New York City residents. Taking into account those not eligible for Medicaid managed care as well as those in other programs eligible only for managed care, we estimate the overall penetration rate for public health insurance beneficiaries as 48 percent (Table 1).** Additionally, with Medicaid’s exemption or exclusion from managed care of many of its most intensive service users, we expect that providers perceive that penetration as much lower than 48 percent, since they are still treating most of Medicaid’s intensive service users on a fee-for-service basis.

**MANAGED CARE PLANS.** Prior to the 1997 federal waiver, three of the eight largest Medicaid enrollers were HMOs with predominantly

---

*For this paper we define public health insurance as New York’s means-tested programs, including Medicaid, Family Health Plus, and Child Health Plus.

**Penetration rate estimates are based on December 2002 data; later statistics on total Medicaid enrollment are not yet available.

---

### Table 1: Managed Care Penetration, New York City, December 2002

<table>
<thead>
<tr>
<th>NYC Enrollment</th>
<th>Managed Care as a Percent of Total Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMC</td>
<td>Medicaid Fee-for-Service</td>
</tr>
<tr>
<td>927,052</td>
<td>1,370,325</td>
</tr>
</tbody>
</table>

Source: New York State Department of Health enrollment reports
commercial enrollment. Placing second behind the not-for-profit HIP was Oxford Health Plan, a for-profit HMO enrolling primarily employer groups. With the repeal in December 1996 of financial penalties for inadequate Medicaid enrollments, the incentive for commercial plans’ participation diminished. By February 2003, two of the three leading plans, plus several other for-profit HMOs, had left the program.

By 1999, 18 plans were enrolling Medicaid beneficiaries in New York City; four of these, down from eight in 1997, were HMOs. Today, there are 17 plans active, five of them HMOs (Table 2). The provider-sponsored plans that dominate the program had been started by hospitals and health centers; most were licensed to serve predominantly public program enrollees, with only a small share of commercial enrollees allowed. By January 2003, more than two of every three of the city’s Medicaid managed care enrollees was in a provider-sponsored plan (Figure 3).

State analysis indicates that the departure of commercial plans did not affect service quality (Roohan et al. 2000). Indeed, provider-sponsored plans without commercial members may be better positioned to focus attention on their low-income members’ needs (R Brown et al. 2001).

Three-quarters of provider-sponsored plans have hospital sponsorship (United Hospital Fund 2000c). Not surprisingly, therefore, provider-sponsored plans are more likely than others to rely on hospital outpatient departments and community health centers for their primary care capacity, where other plans rely extensively on office-based physicians. Most plans pay primary care facilities a capitation payment, although a few pay discounted fee-for-service rates or negotiate global capitations that include primary care in a broader

Table 2: Medicaid Managed Care Enrollment by Health Plan, New York City, February 2003

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Enrollment</th>
<th>Sponsorship</th>
<th>Boroughs Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP</td>
<td>140,000</td>
<td>Other</td>
<td>All</td>
</tr>
<tr>
<td>Health Plus</td>
<td>118,000</td>
<td>Provider</td>
<td>All</td>
</tr>
<tr>
<td>HealthFirst</td>
<td>109,000</td>
<td>Provider</td>
<td>All</td>
</tr>
<tr>
<td>MetroPlus</td>
<td>108,000</td>
<td>Provider</td>
<td>All but Staten Island</td>
</tr>
<tr>
<td>Affinity Health Plan</td>
<td>79,000</td>
<td>Provider</td>
<td>All</td>
</tr>
<tr>
<td>AmeriChoice</td>
<td>79,000</td>
<td>Other</td>
<td>Bronx, Brooklyn, Queens</td>
</tr>
<tr>
<td>Fidelis Care</td>
<td>67,000</td>
<td>Provider</td>
<td>All</td>
</tr>
<tr>
<td>NHP (Neighborhood Health Providers)</td>
<td>62,000</td>
<td>Provider</td>
<td>All</td>
</tr>
<tr>
<td>CenterCare</td>
<td>60,000</td>
<td>Provider</td>
<td>All</td>
</tr>
<tr>
<td>Care Plus</td>
<td>52,000</td>
<td>Other</td>
<td>All but Bronx</td>
</tr>
<tr>
<td>New York Hospital</td>
<td>30,000</td>
<td>Provider</td>
<td>All but Staten Island</td>
</tr>
<tr>
<td>Community Premier Plus</td>
<td>26,000</td>
<td>Provider</td>
<td>Bronx, Manhattan</td>
</tr>
<tr>
<td>St. Barnabas/Partners in Health</td>
<td>22,000</td>
<td>Provider</td>
<td>Bronx</td>
</tr>
<tr>
<td>United Healthcare</td>
<td>21,000</td>
<td>Other</td>
<td>All</td>
</tr>
<tr>
<td>Wellcare</td>
<td>20,000</td>
<td>Other</td>
<td>All but Staten Island</td>
</tr>
<tr>
<td>ABC</td>
<td>8,000</td>
<td>Provider</td>
<td>Bronx</td>
</tr>
<tr>
<td>Community Choice</td>
<td>4,000</td>
<td>Provider</td>
<td>Bronx</td>
</tr>
</tbody>
</table>

NYC Total 1,004,000

Source: New York State Department of Health enrollment reports and New York City Human Resources Administration Medical Assistance Program Fact Sheet, August 2002

Note: Enrollment column does not sum to total because of rounding.
Policymakers at both the city and state levels had turned to managed care as a program model that could remedy many of the problems they had identified in New York’s Medicaid program. Managed care was to:

- **Increase access** to ambulatory care providers both by extending consultation hours and by bringing on board physicians who had not accepted fee-for-service Medicaid payments;
- **Change service use patterns**, eliminating unnecessary emergency department visits and duplicative diagnostic work by connecting each Medicaid beneficiary to a specific source of primary care;
- **Improve quality** by holding plans accountable for their performance on quality measures and for complying with contractual provisions, opportunities which were absent from the fee-for-service model; and
- **Slow growth in spending** through more appropriate utilization and improved services, both ultimately proving less expensive than fee-for-service care.

All of these changes were to be made while protecting critical components of the state’s provider infrastructure. Efforts to do that included giving provider-sponsored plans preference in receiving auto-assigned beneficiaries who did not select a plan; requiring that plans contract with federally qualified health centers; and making supplemental payments to health centers. To assist providers with their transition to managed care during the waiver’s first five years, $1.25 billion was also made available to hospitals through the Community Health Care Conversion Demonstration Project.

For some, managed care was primarily an approach that would change the way services were delivered; for others, its projected

---

**Figure 3:** Medicaid Managed Care, Enrollment by Plan Type, New York City, January 1991-January 2003

Source: United Hospital Fund analysis of New York State Department of Health enrollment reports
financial benefits were paramount. Certainly, some policymakers were much more engaged than others in understanding the amount of upheaval and controversy their decisions would generate (LD Brown and Tallon, forthcoming). Goals not only differed among decision makers but also shifted over time.

In the mid-1990s, cost control became extremely important. A new premium-setting process required plans to bid within a predetermined but undisclosed range, and then to decide within 48 hours whether to accept what the state offered in response (Toohey, Haslanger, and Fagan 1999).

The managed care “medical home” would ensure each enrollee a designated primary care provider, by bringing the benefits of coordinated, comprehensive care into the Medicaid program. Such care is consistently associated with positive outcomes.

Over most of the program's history, however, cost containment has been a secondary goal, receiving only sporadic attention. Its importance diminished as state revenues increased, total Medicaid enrollment declined, and managed care enrollment stalled in the late 1990s.

While perhaps not by design, some policy decisions had the effect of limiting managed care's cost-containment potential. Carving prescription drugs out of the managed care benefit package and placing significant limitations on plans' abilities to reduce payments for emergency department visits are two examples. In addition, the program of provider transition payments was potentially at odds with stringent cost control. Even after managed care enrollment accelerated again in 2001-2002, its potential for cost savings was severely limited by the program's focus on non-disabled children and working-age adults — the lowest-cost Medicaid beneficiaries — and the substantial scaling-back in plans for enrolling more costly-to-serve populations.

More consistently since the program's inception, a central goal of the managed care model was to provide enrollees with a primary care medical home — the antidote to fragmented fee-for-service care. Under fee-for-service, few Medicaid beneficiaries had the benefit of a sustained relationship with a primary care physician. Many beneficiaries visited multiple sites and saw numerous providers, so no one physician had access to information on the patient's history, complaints, or previous diagnostics and treatments (United Hospital Fund 2000d). Other barriers to adequate care included limited numbers of primary care physicians, limited sites providing care after regular business hours, and inadequate translation services. The press of other priorities for low-income families attempting to make ends meet presented barriers of a different type. The fee-for-service model was also replete with avoidable hospitalizations and high rates of emergency department visits for non-emergent conditions (Billings, Parikh, and Mijanovich 2000), low rates of ambulatory follow-up after hospitalizations, and post-partum visits far below recommended levels (Billings 2000).

The “medical home” was shorthand for a construct that would bring the benefits of coordinated, comprehensive primary care into the Medicaid program — ensuring that each enrollee would have a designated primary care provider, one with whom the patient could develop a closer relationship over time, and who would be the gateway to any other services required. Primary care would be available when it was needed, not just during regular business hours; appropriate preventive services and patient education would be part of the package. Such care has consistently been associated with positive outcomes. Researchers have found that having a regular source of care is a strong predictor of adequate access (Lambrew et al. 1996), and that continuity of care is associated with fewer
hospitalizations and emergency department visits (Mainous and Gill 1998; Christakis et al. 1999).

**Achieving the Goals**

To move the program toward the vision of a medical home, policymakers built in several administrative mechanisms, including program design features, financial incentives, and contractual requirements.

**PROGRAM DESIGN FEATURES.** Two key program design features were intended to underscore the importance of primary care providers in managed care. Mandatory enrollment could proceed only where beneficiaries had a choice of at least two managed care plans. And within plans, beneficiaries had to have a choice of no less than three primary care practitioners (McKinney’s Consolidated Laws). Policymakers expected that the extent and distinctive features of each primary care network would be an important factor in beneficiaries’ selection of plans, and that the requirement for choice would create competition among providers. To retain their Medicaid patients, it was argued, providers would need to make their practices more attractive; competition would motivate greater attention to appointment systems, waiting times, and other aspects of customer service, especially among institutional providers, for whom block appointment systems were still the norm.

**A NEW FINANCIAL MODEL.** Managed care’s use of capitation instead of per-visit payments to providers was a radical change in the way services were financed. Instead of paying providers directly for services rendered, states adopting a managed care model pay plans an amount for each enrollee, and plans can then determine how and how much to pay providers. Capitation rates vary with age and aid category, which serve as proxies for likely differences in health care use among potential members. By adopting capitation, the program tried to create incentives for plans to emphasize preventive care and early disease detection. Plans were given the flexibility to abandon the Medicaid fee scale and negotiate directly with providers over payment. Policymakers thought this flexibility enabled plans to direct more resources toward primary care and shift funds away from other services. The rationale may have been that — given the fee-for-service system’s duplicative services and high rates of avoidable hospitalizations and emergency department use — managed care premiums were adequate to enable plans to increase primary care provider payments while still meeting other needs.

**CONTRACTUAL OBLIGATIONS.** New York policymakers wanted to make sure that managed care plans knew what responsibilities they were expected to carry out and what provider standards they were accountable for enforcing. The model managed care plan contract that New York City and other counties were able to adapt for local use specified detailed requirements. Starting with the basic tenet that the primary care provider “will serve as each member’s initial and most important point of interaction,” the contract included provisions on accessibility, staffing, reporting requirements, and more. Each clinician, for example, had to practice two days a week, for a total of 16 hours, at each site where he or she was offered as a primary care provider. Additional provisions detailed the terms under which medical residents could serve as part of the primary care team. Maximum provider-to-patient ratios were established to safeguard against exceeding capacity. Guidelines on appointment times distinguished between emergency care, urgent care, non-urgent “sick” visits, and routine appointments (Toohey, Haslanger, and Fagan 1999). Plans had to submit regular monitoring reports to the state health department on primary care access and availability, including appointment availability and after-hours coverage.
Policy Meets Practice

Policymakers’ high expectations of managed care would require all parts of the system to take on and meet a host of difficult challenges. For program goals to be achieved, three streams of influence — in an interplay of government, plans, providers, and beneficiaries — would need to operate successfully:

• City and state government would have to shape how managed care plans would operate in the Medicaid program;
• Requirements imposed by managed care plans, and primary care providers’ own concerns about remaining competitive, would have to stimulate change in providers’ practices; and
• Plans and primary care providers would have to influence how people use services, and enrollees would need to be responsive to this influence.

While mechanisms had been put in place to support these changes, reality diverged from or was more complex than concept in important ways. Many factors intervened to limit the leverage of the managed care model to change service delivery in the Medicaid program.

GOVERNMENT INFLUENCE ON MANAGED CARE PLANS. Two characteristics of New York’s program created the expectation that government would exercise an extremely high degree of influence over managed care plans. The first was the very detailed and prescriptive nature of the state-approved contract with plans. The second was the departure of many commercial plans from the program, leaving primarily those with little or no commercial enrollment and, thus, near-total reliance on Medicaid for their existence. Those features have been countered, however, by other forces.

Government responsibility for and authority over managed care in New York’s public health insurance programs is fragmented. While the state health department’s Office of Managed Care consolidates quality reporting and oversight for both commercial enrollment and public programs, two other health department units are also involved: the Office of Medicaid Management is responsible for Medicaid eligibility policy and Family Health Plus, and the Office of Planning, Policy, and Resource Development is home to Child Health Plus B. At the same time, the state’s Department of Insurance is responsible for monitoring HMOs’ compliance with statutory financial reserve requirements. In New York City, the local health department engages in broad contract monitoring and oversight, including reviews of marketing plans and materials and monitoring marketing activities, while the Human Resources Administration determines and renews Medicaid and Family Health Plus eligibility and interacts with Maximus, the independent enrollment broker, to complete plan enrollment or, for beneficiaries who do not select a plan, auto-enrollment.

Having so many offices involved in administering a program with so many complexities and requirements creates confusion, contradiction, and frustration — all impediments to effective government influence over plans.

More importantly, perhaps, government’s ability to influence plans is hampered by gaps in the information it receives on managed care members’ use of services. Under fee-for-service Medicaid, providers must submit bills to the state’s Medicaid Management Information System in order to receive payment. The data are problematic in some regards — services and diagnoses not relevant to payment are lost, and not all services provided can be billed — but the assumption is that the system holds a fairly complete, if in some respects flawed, record of services delivered. With managed care, however, because plans receive monthly premium payments from the state based on their rosters of eligible members, and in turn make monthly capitation payments to their primary care providers, the data are less complete and more likely to be inaccurate.
providers, neither plans nor providers need submit service records to receive payment. Although New York has long required plans to provide the state with detailed encounter data on their services to Medicaid members, state officials maintain that these data — particularly those on ambulatory care encounters — are incomplete, and thus of limited utility in efforts to compare managed care and fee-for-service use.

State analysts have been working with managed care plans to determine how encounter data fall short and to improve encounter reporting. Part of their strategy is to publicize plan performance on state Quality Assurance Reporting Requirements (QARR) indicators, which are calculated based on encounter reports. In the past, quality reports often reflected encounter data supplemented by chart reviews to fill in reporting gaps. Gradually, the state has increased its reliance on encounter data alone to calculate those performance scores. In this way, state administrators are creating incentives for plans to attend to their encounter reporting. By using these encounter-driven quality scores as part of the algorithm to award health plan incentives such as auto-assignment and increased premiums, the state further underscores to plans the importance of complete encounter reporting.

While the improved but still incomplete encounter reports leave an information gap in Medicaid data, analysts are at an even greater disadvantage with regard to Child Health Plus B, since plans are not required to submit CHP encounter data to the state at all.

**PLAN INFLUENCE ON PROVIDERS.** Just as the gaps in encounter data limit the government’s ability to influence managed care plans, this same data gap limits plans’ abilities to shape provider practice. But even if better data were available, other factors limiting plans’ influence would still be in play.

Three of the six largest plans in New York’s public health insurance programs are sponsored primarily by hospitals, and hospital outpatient departments are the ambulatory care providers facing the most demanding tasks in reshaping their operations to fit a managed care model. One of the key forces making change both necessary and difficult is the role of graduate medical education. Medical residents play a significant role in staffing hospital outpatient departments, but residents’ obligations to cover inpatient services and meet other institutional priorities effectively impede efforts to introduce continuity of care.

With or without hospital sponsors, managed care plans regularly describe the difficulties they have in getting clinics to be responsive to new demands.

Apart from the special case of outpatient departments, the slow initial pace of Medicaid managed care enrollment in New York City meant that providers were not dependent on plans for large proportions of their patient loads, and plans’ leverage over providers was, in turn, limited. Further, with provider networks overlapping extensively, physicians who have contracts with many plans and only small enrollments from each are not necessarily going to be attentive to the demands of any particular plan.

Provider sites with limited resources — most of the city’s institutional providers during most of this period (United Hospital Fund 2002; Salit, Fass, and Nowak 2002) — have limited ability to respond to plan requirements and will, by necessity, set priorities reflecting their own most urgent interests as much as whatever signals their plans send.

---

**Outpatient departments face the most demanding tasks in reshaping themselves to fit a managed care model. One of the key forces making change both necessary and difficult is the role of graduate medical education.**
In our discussions with them, providers described the extensive administrative burdens that managed care created, requiring staff time to keep track of and comply with each plan’s reporting requirements, referral networks, and referral procedures. They also pointed to the state’s longstanding cap on fee-for-service outpatient rates as an impediment to change.

This is not to say that ambulatory care services have not changed at all. In fact, some important improvements — greater evening and weekend access to physicians, decreased wait times for appointments and cycle times at patient visits — have occurred because providers anticipated new managed care requirements and recognized an increased sense of competition for Medicaid patients. Other needed changes, however, such as the availability of trained translators, still fall far short of expectations (United Hospital Fund 2001b).

PLANNED AND PROVIDER INFLUENCE ON ENROLLEES.
The incredible distraction and disruption that episodic Medicaid coverage creates is, very likely, the greatest impediment to managed care plans and providers being able to influence the way beneficiaries use health care services. A plan or provider’s efforts to make sure a patient gets good primary and preventive care is an investment, an expenditure that will bear positive returns over time but not necessarily in the first instance. The realities of Medicaid eligibility are at odds with this longer-term approach.

Many states, New York included, have adopted guaranteed eligibility periods to ensure that enrollees have at least six months of coverage, but that is hardly enough time to accomplish a fundamental reorientation toward care-seeking. Moreover, that six-month period is sometimes truncated because eligibility is established retroactively or because systems glitches or other problems result in a loss of coverage before the end of the guarantee period. Most managed care enrollees are non-disabled parents and children, some receiving Medicaid benefits alone, many receiving cash assistance as well. Only about two-thirds of those receiving both manage to retain their Medicaid eligibility for a full year; just over 40 percent of those on Medicaid alone have a year of uninterrupted coverage (Haslanger 2002). Plans have reported a turnover of almost half their members over the course of a year, through involuntary disenrollment generally attributable to lost eligibility (Bachrach and Tassi 2000).

The fact that so many beneficiaries lose coverage within a year, and that getting and keeping Medicaid requires so much time and attention, renders financial incentives for prevention and early detection fairly meaningless. Even among beneficiaries who keep their coverage and stay in a single plan for 12 months, QARR analyses found, more than a quarter of Medicaid managed care enrollees ages 20 to 44, and nearly a fifth of those ages 45 to 64, had no record of a primary care visit (New York State Department of Health 2001, 2002). And while there are ample reasons to expect differences between Medicaid and commercial members, it is notable that the share of Medicaid members with no visit is twice that of privately insured managed care enrollees.

Other factors also leave plans and providers with little time to engage members in discussions of how to use the health care they are entitled to receive. Along with administrative efforts they expend on helping Medicaid and other public insurance beneficiaries obtain and keep their coverage, managed care plans invest substantial time in marketing plan membership and ensuring that new members actually appear on plan rosters. The question of how plan choice and enrollment should be managed has been contentious. Procedures also vary across programs, reflecting different program histories. Because patient advocates regarded Medicaid managed care as a diminution of coverage, extensive safeguards were put in place to ensure
informed choice by beneficiaries. Child Health Plus B and Family Health Plus, in contrast, represented coverage expansions for persons formerly uninsured, so did not raise the same level of concern about choice. In some respects, rules created to protect beneficiaries actually inhibit the exchange of information that could lead to more informed plan choice. For example, marketing rules prohibit plans from querying prospective members on special health care needs. While this prohibition safeguards against plans’ avoidance of high-risk patients, it also makes it more difficult for plans to offer prospective members specific information about network providers’ expertise on conditions important to that member.

Data system requirements, too, have created differences in enrollment procedures among programs. Medicaid and Family Health Plus must meet the more stringent requirements of the state’s archaic but comprehensive Welfare Management System; Child Health Plus B records reside in a newer, more limited system designed specifically for the program. Data system issues also contribute to the difficulty of maintaining coverage across transitions, as family circumstances change and family members shift between Medicaid and the expansion programs.

Real-World Impact

Given all these constraints, what measurable effect has managed care had on the Medicaid program? In our work with the Consortium we assessed the program’s impact on access, service use, quality, and costs.

ACCESS. Both the number of participating providers and their availability to patients are important dimensions of access to care. Efforts to increase the number of participating providers and patient access to them will be severely undercut if accompanied by financial stresses on providers serious enough to limit the scope and hours of service, or to require cutbacks in outreach, translation, or other features geared toward helping Medicaid enrollees overcome non-financial barriers to care.

Our assessment found that managed care did increase the number of primary care providers serving New York City’s Medicaid patients. Managed care’s impact on access is especially important in New York City, where a shortage of primary care providers had been well documented (Brellochs et al. 1990; Soffel, Fraser, and Patel 2000). Efforts to build new capacity had been underway since the early 1990s, supported by philanthropy as well as public funds, particularly in low-income neighborhoods. The city’s phase-in

The fact that so many beneficiaries lose coverage within a year, and that getting and keeping Medicaid requires so much time and attention, renders financial incentives to plans for prevention and early detection activities fairly meaningless.
They commissioned an independent study to identify how many providers were available, how Medicaid enrollment was distributed geographically in relation to provider location and public transportation lines, and what national research suggested as reasonable standards for provider panel size. This analysis concluded that, while difficult to gauge, provider capacity was probably adequate to support mandatory enrollment in the first geographic phases of the city’s plan, but that problems loomed in the areas slated for later enrollment, unless the number of providers were to increase (Billings, Greene, and Mijanovich 1998). In the intervening years, Medicaid enrollment decreased and new ambulatory care sites opened, so capacity has not been a barrier to program implementation.

Judgments about provider capacity were further complicated by policymakers’ sense that capacity was dynamic. Researchers had noted that many community-based physicians refused to see Medicaid fee-for-service patients because reimbursement rates were only $7 to $11 per visit. But policymakers expected that commercial plans, required to demonstrate their willingness to serve Medicaid enrollees, would bring their broader networks of office-based physicians into the managed care program, supplementing and perhaps even supplanting hospital outpatient departments and community health centers where Medicaid beneficiaries often turned for primary care.

Those expectations about commercial plans’ abilities to increase access far exceeded the reality in New York City, since the plans did not make their full office-based panels available to Medicaid beneficiaries. The New York City Office of the Public Advocate documented this phenomenon of dual provider lists — one for Medicaid and a much broader one for commercial accounts. But although the federal waiver required participating plans to make at least 80 percent of their commercial provider rosters available, most commercial plans left the program entirely before compliance could become an issue. Still, while few commercial plans stayed in the program, state analysis finds that commercial plans have brought additional capacity to New York City, and have had a tremendous impact outside the city (Shure 2003).

An independent assessment of provider participation in 2000 concluded that Medicaid beneficiaries in managed care had access to larger numbers of providers than did fee-for-service beneficiaries. Additionally, managed care physicians were more likely to be board certified and to have hospital admitting privileges than those participating only as fee-for-service providers (United Hospital Fund 2001c). This increased capacity was realized despite the fact that fewer than half of all Medicaid fee-for-service physicians signed on to a managed care panel. Physicians participating only in fee-for-service were generally seeing few Medicaid patients (73 percent reported that less than 10 percent of their patients were covered by Medicaid) and nearly half did not meet managed care’s prerequisites for being primary care providers (Schreiber et al. 2001).

Managed care plans and community advocates generally agree that Medicaid beneficiaries also have access to a broader range of providers under managed care. Both groups point to improved access to specialists, a result of plans’ particular efforts to recruit specialists who did not accept fee-for-service Medicaid patients (Roundtable participants 2002). Increased access to office-based specialists is an important benefit of managed care. Under fee-for-service Medicaid, beneficiaries have few choices beyond hospital outpatient departments for specialty care. With rotating medical residents playing a substantial role in delivery of outpatient clinic services, these settings are not conducive to developing long-term patient-provider relationships and pose real challenges for coordination of care.

Beyond sheer numbers of practitioners and sites, providers’ actual availability is a crucial
dimension of access. Traditional Medicaid fee-for-service providers had been criticized for making appointments only during daytime business hours, creating access barriers for low-income workers without flexible work schedules and for children in school. Further, traditional providers’ practice of closing their offices without coverage at the end of their regularly scheduled appointments meant that patients with problems arising after hours were left with little choice but to make a trip to the emergency room, since they had no other place to call for advice.

Surveys of Medicaid-participating ambulatory care providers performed as early as 1996 indicated that most had remedied these shortcomings in anticipation of the standards they would be required to meet under managed care contracts and the patient expectations they would raise as they sought to act more like a medical home. By 1996, most sites offered evening or weekend appointments, and a substantial share had after-hours coverage. A later survey, in 1999, found that providers had been able to sustain enabling services such as outreach, transportation, and entitlement assistance for low-income patients; at that time, providers were generally not undercutting these improvements by adopting other policies that could impede access. Few providers, for example, had instituted hard and fast policies of turning away Medicaid patients who were enrolled with another primary care provider. While ambulatory care providers faced financial stress and uncertainty, these conditions seemed to arise more from declining numbers of Medicaid beneficiaries and other reimbursement changes than from the managed care model.

To determine whether gains in access for Medicaid patients came at the expense of new restrictions on the uninsured, given the negative margins and year-to-year financial uncertainties facing many community-based providers, our surveys also tracked sliding fee scales and collection policies for those without insurance. Providers surveyed did not report changing their policies, but we did find substantial differences among providers with regard to sliding fees. We found that community health centers and Health and Hospitals Corporation facilities saw larger shares of uninsured patients than did other providers, a pattern that seemed to predate managed care.

Despite these important improvements in access, through broader provider participation and enhanced provider availability at traditional sites, research from other states raises concerns that in subtle ways managed care’s requirements still raise barriers to care. Patients used to seeking care from a variety of sources were now enrolled in plans that relied on a designated primary care provider to serve as the gatekeeper to specialty access. Studies that found greater unmet need among managed care enrollees when compared to those in fee-for-service suggest that access points and even provider policies may not tell the full story (Lillie-Blanton and Lyons 1998; Salganicoff, Wyn, and Solis 1998). In 2002 roundtable discussions, community advocates raised concerns that managed care rules were constraining service use for beneficiaries who did not understand how to navigate unfamiliar systems.

**SERVICE USE.** Do managed care enrollees use services differently than those in fee-for-service Medicaid? What changes can we observe, and do they seem generally beneficial or do they raise concerns about managed care posing barriers to access? Although encounter data are not deemed complete enough to
answer these fundamental questions conclusively, available information suggests that policymakers’ high expectations that managed care could leverage fundamental change in utilization patterns have not been met.

The most straightforward way to determine whether managed care has changed utilization patterns would be to compare managed care records with fee-for-service records, controlling appropriately for beneficiary characteristics. Some rough indicators such as change in the frequency of emergency department visits or avoidable hospitalizations could then be calculated. While such a comparison might not determine whether utilization or quality has improved, we could at least assess whether it has changed. Despite New York’s relatively long history of managed care enrollment, no large-scale comparisons between the two systems have been made available. State program managers argue that managed care plans’ encounter data are both incomplete and unsuitable for comparison with fee-for-service payment claims. While reporting has improved in recent years, they acknowledge difficulties in data acquisition for plans making capitation payments to their primary care providers, as do most of New York City’s participating plans (United Hospital Fund 2000c). Further, a managed care “encounter” is defined differently from a fee-for-service visit, so adjustments would be required before whatever data do exist could be compared.

Again looking to the experience of other states, available research suggests that managed care has had a very modest impact on service use. Drawing clear conclusions is confounded by state-to-state differences in managed care programs, their underlying Medicaid programs, and provider and patient practices. The Kaiser Commission on Medicaid and the Uninsured reviewed 130 studies and found that managed care reduced emergency department use. This finding is difficult to interpret, however, because the review also concluded that managed care had no direct effect on physician visits (Rowland et al. 1995). Relying on a national survey, Urban Institute researchers subsequently found that both adults and children in mandatory Medicaid managed care were less dependent on emergency departments as usual sources of care when compared to fee-for-service beneficiaries; in addition, they were more likely to have visited a doctor. At the same time, adults in managed care were more likely to report unmet medical or surgical needs than were their fee-for-service counterparts, echoing the findings of earlier studies (Zuckerman, Brennan, and Yemane 2002).

Absent clear findings directly from New York data or inferentially from the experience in other states about how service use compares under the two systems, we turn to our understanding of New York’s underlying Medicaid program — as well as perspectives offered by ambulatory care providers, managed care plans, government officials, and community advocates — to identify the kinds of changes that may be taking place.

The concept of a stable medical home is central to Medicaid managed care. Under fee-for-service Medicaid, our research found, many beneficiaries periodically lost their coverage. Those who did retain coverage tended to seek care from multiple sources: prior to managed care, most Medicaid beneficiaries used more than one provider for primary care services, and only about 18 percent of children and 13 percent of adults could be considered “loyal,” meaning that they made three or more primary care visits to the same provider during the three-year study period.
Medicaid Managed Care in New York

That Medicaid enrollment is highly episodic was one of the most important discoveries for managed care plans. As discussed above (see page 12), the implications are profound for everyone involved. Plans have difficulty communicating effectively with members about how to get care — about their right to receive a primary care appointment for urgent needs without delay or to have after-hours access to a qualified provider, much less how to fulfill the requirements for being seen by a specialist. Members who are juggling many more immediate demands have little time to focus on plan messages and requirements and certainly don’t have enough experience with a different system of care to change their long-held patterns and expectations.

Primary care providers, charged with assuming responsibility for the population under their care, emphasize that their rosters change so quickly that they cannot effectively reach out to patients and educate them when they are likely to disappear from their panels in another month. A five-state survey of low-income adults found that nearly one-third of Medicaid managed care enrollees did not report having a regular physician, suggesting that New York is not alone in facing this gap between theory and practice in managed care (Lillie-Blanton and Lyons 1998).

While a national survey found reduced reliance on the emergency department among Medicaid managed care enrollees, it is unclear whether New York is also experiencing this shift. Managed care plans widely acknowledge that they have “thrown in the towel” when it comes to emergency department use, identifying short spans of eligibility as only one of several impediments. Plans argue that they have no effective tools to use with either their members or with emergency departments, so chances of changing longstanding care-seeking behavior are slight. Commercially insured members customarily face financial penalties for visiting the emergency room for care that could suitably be delivered at another time in a less costly setting. But Medicaid policy, formalized in the Balanced Budget Act of 1997, prohibits applying those kinds of financial rules to Medicaid beneficiaries, and New York’s hospitals have lobbied effectively against payment policies that would reimburse non-emergent visits at a lower rate.*

Despite these challenges, most plans have established a variety of case management programs in order to change utilization and improve care for particular conditions. The most common of these focus on asthma treatment and pregnancy. Yet enrollment tends to be low, and plans report great difficulty in collecting data from providers on ambulatory visits and on quality of care measures, making case management programs challenging to implement and nearly impossible to evaluate (United Hospital Fund 2001a).

QUALITY. Whether or not we can discern a significant impact on service use, we may still find that managed care has increased the overall quality of service for Medicaid beneficiaries. Without question, managed care plans provide a framework for measuring service quality that had no parallel in the old fee-for-service system. And when problems are discovered, plans provide a vehicle for accountability and improvement. Still, national findings on the impact of managed care on quality are mixed and incomplete, suggesting that managed care can take further steps toward improving quality. As with assessments of service use, gaps in the available data preclude drawing clear conclusions in New York.

* State policy has established a triage fee for non-emergent visits. Plans minimize the utility of this policy because of the requirements they must fulfill in order to justify paying only this fee.
New York State has made a substantial investment in strategies for using managed care plans as levers for improving service quality under Medicaid. With QARR, New York was a pioneer in developing quality measures specific to the Medicaid program. The state's Bureau of Quality Management and Outcomes Research publishes annual reports on how commercial plans as well as PHSPs perform on a range of dimensions, making comparisons to national averages or policy goals, as appropriate. The Bureau’s annual reports compare plan performance from year to year (the 2002 report, for example, compares 1999 and 2001 scores) in areas such as women’s health and well-child visits.

New York makes its QARR results widely available. Five regional guides, including one for New York City, are distributed in English, Spanish, Russian, and Chinese, to assist Medicaid beneficiaries in choosing their plans. But while community organizations that counsel beneficiaries give the state high marks for its efforts to measure and publicize plan performance, they note that beyond a few measures related to asthma and antidepressant medications, QARR and the consumer guides emphasize wellness visits and standard screenings, giving little specific information to those with chronic illness or disabilities. Although most Medicaid beneficiaries with serious disabilities and long-term care needs are excluded from enrolling in managed care, the mandatory groups do include many with chronic illnesses and some plans report members with complex health needs. Moreover, because QARR reports cover plans in their entirety, they provide no information about variations among providers within plans that could assist beneficiaries in selecting a primary care provider.

Nor do these reports compare managed care with fee-for-service outcomes, limiting QARR’s ability to document service change. Some of this information is available for other states, however. When managed care and fee-for-service are directly compared, fee-for-service lags behind on important measures like timely immunizations for children, comprehensive diabetes care, and breast cancer screenings (Smith and Hamacher 2003).

Managed care offers a distinct advantage by giving states a framework for quality improvement unavailable with the fee-for-service model. In addition to translating QARR scores into consumer guides, for example, state administrators devised an internal tool to assist managed care plans with developing and prioritizing quality improvement activities. The tool incorporates changes in plan scores over time as well as performance scores relative to other plans. In 2001, the state also began factoring plan performance into the formula used for auto-assignment of Medicaid beneficiaries who have failed to choose a plan on their own. Additionally, the state created a 1 percent premium incentive to reward plan performance.

Speaking to people with different vantage points, we heard a range of opinions about the real impact these measures have had on improving service quality (Roundtable participants 2002). State program administrators point to year-to-year improvements in QARR performance, as well as areas where New York plans outscore national Medicaid benchmarks, as evidence that their efforts have had an impact. Some plans describe extraordinary efforts that they have made — investing substantial resources and demonstrating real creativity — to improve performance on a particular measure. Other plans, and some providers, attribute year-to-year gains to increased investment in data capture. Providers voice confusion about the feedback they get, when they find one plan giving a high score and another giving a low score to the same provider for the same measure.

Consistent with participants’ comments, research from one demonstration project found that plan feedback often goes directly to individual providers, bypassing the management structure that might have organized quality improvement activities (Fairbrother,
Luciano, and Park 2002).

Many types of quality improvement require providers to make changes in service delivery, and it is difficult to conclude that plans have had enough leverage over providers to be a catalyst for fundamental change. Slow implementation and low penetration rates are an important part of this story. The 1999 United Hospital Fund/NYU ambulatory care provider survey — conducted when citywide Medicaid managed care penetration was roughly 20 percent, where it remained until 2001 — found that managed care covered only about 20 percent of Medicaid visits, and an even smaller share of providers’ total workload (United Hospital Fund 2000a). The recent jump to 61 percent penetration, combined with the impact of the managed-care-only Family Health Plus and Child Health Plus programs, however, may give some of the larger plans substantial visibility and clout with participating providers.

Despite higher penetration, though, plans still face real limits to their ability to influence their overlapping panels of providers. Even hospitals and health centers that sponsor health plans do not have exclusive arrangements with their own plans. Again, since they are not driving a high volume of any individual provider’s patient load, plans argue, they have little leverage to force substantial changes in how providers practice.

Additionally, some types of providers are particularly insulated from change. With hospitals or groups of hospitals sponsoring 75 percent of city plans (United Hospital Fund 2000c), a substantial portion of the ambulatory care delivery system is outpatient department-based. The problem of balancing the requirement of continuity in patient care with the demands of graduate medical education is a thorny one, and managed care policy has not proved a sufficient counterweight for the imperatives of large institutionally based teaching programs.

In turn, ambulatory care providers describe all of the confusion and additional paperwork requirements with which they must contend under managed care. Most health centers and hospital outpatient departments have contracts with several plans. Each plan has credentialing procedures for individual primary care practitioners, a unique set of rules for how to make a specialist referral, and its own referral network for specialists and ancillary services. And these networks and procedures are not static. Health centers displayed the elaborate grids and tracking systems they have developed just to stay on top of the procedural requirements of managed care. Providers have to take these procedures seriously so they can get paid and so their patients can get access to the care that they need, but tending

Ambulatory care providers describe the confusion and additional paperwork with which they must contend. Dealing with these myriad requirements may well be diverting management energies from other more care-focused issues.

to these myriad requirements may well be diverting management energy from other more care-focused issues.

COST. New York embraced managed care as state policy in the midst of a budget crisis, at least in part because of its potential to rein in cost growth. Enrollment has been slow, and has been confined to the least costly categories of beneficiaries, so extensive cost analysis seems premature. Research from other states is very limited; one study claims savings, and another suggests that managed care may actually increase costs.

In order to receive federal authority to mandate managed care enrollment New York had to pledge that its program would be budget neutral. That is, state and federal officials negotiated agreement over key assumptions about how spending was likely to
Now that managed care has been adopted as the service delivery model for most public health insurance programs, policymakers have even greater opportunity to make changes that will strengthen these programs.

All forms of managed care have been controversial in part because some studies have found that managed care enrollees are healthier than the general population. Since managed care premiums are based on overall expenditures, purchasers would be overpaying for managed care. Our analysis of New York’s program did not find evidence of program-wide selection bias. Comparing fee-for-service use of those who later enrolled in managed care with use by those who remained in fee-for-service, we found that those who enrolled in managed care were neither sicker nor healthier than those who did not (United Hospital Fund 2000b).

Still, one important limitation on managed care’s ability to generate substantial savings has been New York’s focus, up to this point, on enrolling non-disabled children and their parents. For this least-costly group of beneficiaries, annual fee-for-service spending averaged roughly $2,000 per child and $4,000 per adult. In contrast, spending for the elderly and disabled — both groups generally excluded from managed care enrollment — represents nearly 70 percent of total Medicaid costs, at more than $20,000 annually per beneficiary. Thus, managed care would have to derive extraordinary savings from its low-expenditure base to affect overall spending substantially.

Analysts have generally concluded that commercial managed care generates savings by negotiating discounted fees with providers, and by implementing stringent payment policies that carve out days from hospital stays. Medicaid has generally been regarded as a reasonable payer for inpatient services but certainly not a generous one for ambulatory care. In addition, some national studies are indicating that providers are beginning to drive harder bargains with plans, in part to make up for Medicare cuts. Thus, plans have had little room to find discounts on the largest categories of service use for which they are financially responsible. Prescription drugs, on which additional discounts could have been realized, are outside the managed care benefit package.

The vast number of administrative requirements implicit in Medicaid managed care also means that the model entails costs beyond those incurred in fee-for-service care. Indeed, a California study found that Medicaid spending increased as a result of the managed care mandate, without observable improvements in health outcomes (Duggan 2002).

Some of those costs arise from government officials’ having to negotiate contracts with plans, monitor key aspects of performance, regularly measure and report on service quality, and watch plans’ financial solvency. These responsibilities are layered on top of the state’s ongoing role in regulating health care providers. In addition, managed care adds considerable complexity — and therefore administrative costs — to the enrollment process: beneficiaries need to know whether they are required to select a plan, what their choices are, how to decide, how to use ser-
services once enrolled, and what their rights are. Program observers may disagree about how well these information needs are being met, but there is no question that they represent additional expenditures that would further limit any savings plans might have realized.

**Recommended Actions**

Managed care in New York has had many positive effects: increased primary care access, a broader selection of community-based specialists, and a framework for measuring and improving quality. At the same time, our multi-year assessment of New York’s managed care initiative finds that the premise of managed care — that new financial incentives would bring fundamental change to the delivery system — has been difficult to achieve for a variety of reasons.

In addition to its benefits, managed care also created new complexity. With the introduction of plan enrollment and new rules about getting access to care, it added more moving parts to the already complex machinery of public health insurance. It raised new expectations, and brought in a new set of organizations — managed care plans — with new responsibilities. With these changes comes increased attention to government’s role in maintaining quality and accountability, raising concern about the multiple agencies, overlapping activities, and imprecise data systems currently involved in carrying out this role.

Now that managed care has been adopted as the service delivery model for most Medicaid beneficiaries, and is the sole option for those in Family Health Plus and Child Health Plus B, policymakers have even greater opportunity to make program changes that will strengthen these programs.

- **Assess and affirm Medicaid managed care’s role in delivering services to a diverse low-income population.** Medicaid managed care was created when the entire health care system was moving toward comprehensive payment for integrated service delivery. Since then, this strategy has been questioned and commercial insurance purchasers are turning their backs on managed care models.

Increasingly, public programs are alone, rather than part of the mainstream, in pursuing this strategy. Yet our examination found neither an inclination to return to the fee-for-service system nor an interest in developing new “consumer driven” approaches. In this context the managed care model’s capacity to effect fundamental change in service delivery for low-income populations requires a fresh consensus from government payers, managed care plans, health care providers, and consumers. This consensus must reflect a shared understanding of how managed care will balance the competing demands of service improvement and cost containment.

As this consensus is achieved and policymakers take steps to shape the evolving program, the need for timely and open information exchange and discussion among all those involved in making managed care work will become even more important. At present, different government offices have work groups with various subsets of program participants. The state health department meets with two different statutory advisory committees, one looking only at Medicaid managed care and the other looking at the larger Medicaid program. Neither of these advisory bodies has clear authority to review all three public managed care programs.

It is urgent that the state initiate a regular forum in which policymakers, plans, providers, and advocates can not only exchange information and voice concerns but also assess developments and review policy across the three managed care programs. If this forum were constituted as an advisory body it could be charged with making an annual report to the legislature, with particular attention to identifying areas where statutory change is required.
• **Simplify and stabilize eligibility for coverage and managed care plan enrollment.** Managed care depends on timely and continuous coverage; on its own it simply cannot overcome the high level of instability in Medicaid enrollment that marks the current system. As attention turns to service change, this instability becomes an increasingly significant barrier to success. With average periods of Medicaid coverage growing shorter as managed care penetration has increased, there is a fundamental mismatch with the philosophy of managed care, which emphasizes prevention and continuity over time.

The administrative barriers to program participation have been well documented (Dutton and Fairbrother 2003; Bachrach and Tassi 2000; Birnbaum and Holahan 2003; Perry 2002), as have the discontinuities that arise when low-income individuals’ circumstances change, creating the need to move from one public program to another. Volumes have been written about how to simplify the initial application process and documentation requirements (Care for the Homeless 2001; Aspengren, Soffel, and Wunsch 2003; Erickson and Yacknin 1999; Lawler 2003), as well as the recertification process.

Managed care plans have played a critical role in facilitating new program enrollment as well as eligibility renewal. But this assistance has come at a price: one plan estimates that it spends as much as two months of premiums on administrative tasks related to enrollment and renewal. Government policymakers, working with plans, providers, and community advocates, need to reassess current policies and practices in light of the barriers to care they create, and the limits they place on managed care’s efficacy. Program integrity concerns must be addressed, but application and renewal rules must be evaluated in light of the technological advances that they stymie — such as the optimal use of electronic data capture, storage, and transmission for eligibility determination — and the administrative costs they entail for both government and community enrollers, including health care providers and managed care plans. These costs must be weighed against a realistic assessment of the fraud that they deter, as well as the system costs of delaying health care for eligible beneficiaries who go without coverage. Paying premiums without simplifying and stabilizing coverage at the same time stands to cost, not save, public dollars.

• **Redesign primary care delivery.**

Emerging epidemics such as obesity and diabetes underscore the critical role of comprehensive, coordinated primary care and provider continuity. An important impetus for bringing managed care into Medicaid was that the medical home this would create would offer beneficiaries just that, and thus better care. Program experience to date shows that managed care plans and quality measures can play an important role in working toward that goal, but it is not realistic to expect managed care to accomplish this overhaul alone. This is a special challenge where primary care is provided within more complex health care organizations.

Analyses of provider performance data suggest that not all outpatient departments and community health centers are starting from the same point. Some are already performing much better than others in terms of keeping their loyal primary care patients out of the emergency department, and averting inpatient stays. But the barriers to broad-based reform are formidable, and it is not realistic to expect managed care plans to accomplish this change on their own, simply by virtue of contractual requirements.

Without abandoning the managed care model, policymakers can work with plans and ambulatory care providers to better understand the barriers to desired changes in service delivery, and to identify an array of policies that can stimulate and support these changes. A continuing state role is also required to encourage and assist hospitals to redesign outpatient departments, as well as to establish and main-
tain financial stability for community-based providers, and to bring more office-based physicians into the stronger relationships with other services that low-income families need. Fundamental primary care change requires leadership and support from many different state policymakers, both within and outside of the managed care arena.

The institutional providers that represent a large share of Medicaid’s ambulatory care capacity need to embrace this agenda for change as well. The competing objectives of institutions must give way to effective primary care design for Medicaid managed care to succeed.

- **Devise service strategies for high-cost cases that will improve the quality of care while controlling cost growth.**

  Managed care’s planned utility as a means of controlling Medicaid costs was limited, from the outset, by a program design that effectively barred whole categories of patients requiring costly services. After more than a dozen years, New York is just beginning its engagement with high-cost cases through HIV Special Needs Plans and by encouraging SSI beneficiaries in some counties to enroll in managed care. At this point, however, most of Medicaid’s most expensive beneficiaries are still excluded.

  The ability of managed care to provide appropriate and effective services to high-cost Medicaid enrollees remains, for the most part, untested. Given the experience with lower-cost enrollees, however, it seems likely that plans lack the even greater leverage that would be needed to improve quality and control costs in managing high-need patients. These complex cases thus provide policymakers with another opportunity to test new approaches. Involving providers in that process is essential: as one evaluation of Medicare case management projects found, the failure to engage physicians in devising interventions was a prime reason for the projects’ failure to improve care or reduce spending (Eichner and Blumenthal 2003).

  Working with providers and consumer advocates, policymakers should begin by outlining the service delivery changes needed to improve care, before considering the financing options that would support those changes. Capitation or some other alternative to fee-for-service payments may well be required to align financial and service incentives, but it would be a mistake to again assume that a change in financing method will necessarily change service delivery. Needed service changes must first be identified, and then the financial and regulatory policy changes made that will facilitate successful implementation.

---

**Instability in Medicaid enrollment is a significant barrier to success.** Issues of program integrity must be addressed, but administrative costs must be weighed against the fraud they actually deter, and the costs of delaying care for eligible beneficiaries.

---

- **Rationalize the administrative structure and requirements for plans and providers.** Multiple points of government supervision, and the administrative overload created when different offices specify different requirements across different programs, ensure a level of complexity that distracts program participants from the primary goals of managed care. Plans must deal with the demands of overlapping government bureaus, providers face an array of requirements from every managed care plan with which they’ve contracted, and both plans and providers point to duplicative monitoring and surveillance activities. At the same time, all those layers of supervision notwithstanding, the system’s reliance on indirect quality measures rather than on the tracking of patient activity is a major impediment to accurate assessment of managed care’s success. The state’s conclusion that encounter data are incomplete...
means that policymakers, patient advocates, and the service delivery system itself are left without basic information on service use. While a focus on an increasingly robust set of quality measures, along with other surveillance mechanisms, is arguably adequate for some populations, the move toward enrolling the more vulnerable segments of the Medicaid population again raises the question of whether there are adequate substitutes for complete encounter reporting.

There is an urgent need for policymakers to standardize, rationalize, and simplify reporting requirements and processes.* In doing so, questions of priorities will certainly arise: some program elements are receiving multiple layers of scrutiny, others go unmeasured, and the rulebook is so bulky that regular measurement of every required dimension is probably not realistic. Representatives of all participants in the managed care program — policymakers, plans, providers, and enrollees — need to assess what factors or measures make sense as indicators of plan performance and what measures best assess provider performance, and adjustments in reporting and accountability must be made accordingly.

By adopting the managed care service model, New York has taken important steps toward remedying the shortcomings of fee-for-service Medicaid. Despite its difficulties, managed care remains a potential lever for service improvement. Our challenge is to take the additional steps necessary for this potential to be realized. Government policymakers, managed care plan leaders, ambulatory care providers, and consumer advocates constitute a powerful resource, a community of talent, skill, and commitment that, working together, can fashion and implement these needed changes.

---

* The State Fiscal Year 2004 executive budget proposed shifting responsibility for contracting from local districts to the state, to streamline the contracting process as well as government oversight. Community advocates saw the transfer as incomplete because it did not explicitly vest the state with all of the responsibility that local districts had under current law. The proposal was not enacted.
REFERENCES


McKinney’s Consolidated Laws of New York Annotated Social Services Law, Ch. 55, art. 5, title 11, sec. 364 – j (4) (b) and (c).


Roundtable participants, United Hospital Fund Medicaid managed care roundtables. Summer 2002.


Smith V and L Hamacher. 2003. The good olde days of fee-for-service were not so good after all: Managed care has made things better. Working paper prepared for the Association of Health Center Affiliated Health Plans. Lansing, MI: Health Management Associates.


Related
United Hospital Fund
Publications

*Health Insurance Coverage in New York, 2001*
This chartbook pays special attention to the 70 percent of uninsured New Yorkers who are working, and to trends in enrollment in public health insurance programs.
2003

*New York’s Disaster Relief Medicaid: Insights and Implications for Covering Low-Income People*
A collaboration between the Fund and the Kaiser Commission on Medicaid and the Uninsured, this report presents the findings of a study of New Yorkers enrolled in Disaster Relief Medicaid, and offers lessons drawn from that program and policy implications for public health insurance.
2002

*Redrawing the Line: The Changing Shape of New York’s Health Insurance Crisis*
This update examines the shifting demographics of public health insurance — how minimal change in the overall number of uninsured belies a loss of coverage among New York’s very poorest — and distills lessons for the future from the successes of innovative new initiatives.
2002

**Working Papers**

*Child Health Plus: The Impact of Recent Policy Changes on Enrollment and Utilization Behavior*
2000

*Hospital Markets, Policy Change, and Access to Care for Low-Income Populations in New York City*
2000

*Implementing Express Lane Eligibility in New York State*
2000

*Inside Medicaid Managed Care Contracts in New York City: An Analysis of Plan Contracts and Related Documents*
1999

*Linking Public and Private: Options for Buying-in to Employer-Sponsored Health Insurance Coverage with Medicaid and S-CHIP Funds*
2000

*Medicaid Eligible but Uninsured: The New York State Experience*
2000

*Medicaid Eligibility and Welfare Reform in New York City*
2000

*Proposals to Simplify, Equalize, and Expand Health Care Coverage for Uninsured Working New Yorkers*
1999

*Renewing Coverage in New York’s Child Health Plus B Program: Retention Rates and Enrollee Experiences*
2003

*Toward a Typology of Medicaid Managed Care Plans: The New York City Experience*
2000

*Uninsured Workers and Their Access to Employer-Sponsored Insurance in New York State, 1995-1999*
2000

The full text of each of these papers, and information on other Fund publications, is available online at http://www.uhfnyc.org, or by writing to the Publications Program, United Hospital Fund, 350 Fifth Avenue, 23rd Floor, New York, NY 10118-2399 (shipping charges may apply).
Additional copies of this United Hospital Fund Special Report, @ $20.00 plus $3.50 per order for postage and handling, may be ordered on the Fund's Web site, www.uhfny.org, or from the Publications Program, United Hospital Fund, Empire State Building, 350 Fifth Avenue, 23rd Floor, New York, NY 10118.