ANALYSIS OF SELECTION EFFECTS IN NEW YORK CITY'S MEDICAID MANAGED CARE POPULATION PRIOR TO MANDATORY ENROLLMENT

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ABSTRACT

It is becoming increasingly apparent that over the next several years the majority of Medicaid patients in many states will become enrolled in managed care plans, some voluntarily, but most as the result of mandatory initiatives. An important issue related to this development is the extent to which this movement to managed care is accompanied by serious selection effects, either across the board during the phase in or among individual plans or plan types with full-scale implementation. This paper examines selection effects in New York City between 1993 and 1997 during the voluntary enrollment period prior to implementation of mandatory enrollment pursuant to a Section 1115 waiver. No substantial selection bias was documented between patients entering managed care and those remaining in the fee-for-service system among the largest rate groups, although some selection effect was found among plans and plan types (with investor-owned plans enrolling patients with lower prior utilization and expenses).

INTRODUCTION

It is becoming increasingly apparent that, over the next several years, the majority of Medicaid patients in many states will become enrolled in managed care plans, some voluntarily, but most as the result of mandatory initiatives. Of course, this development, which is being implemented at the state and local levels, raises enormously important questions for vulnerable populations covered by Medicaid and the providers who traditionally have provided their care. Will the plans have primary care practitioner capacity sufficient to ensure timely and effective...
access to care? Do the plans have adequate management structure to administer this transition and to track utilization and quality of care among its contracted providers? Are the plans financially viable? Will patients be able to make informed choices in selection of plans? How will patients, who have historically utilized multiple providers, adapt to managed care restrictions on where they get care? Will Medicaid patients be drawn away from traditional safety net providers, undermining their financial viability and threatening their capacity to provide care to uninsured patients? Are the rates paid to plans adequate to cover needed care and to support the infrastructure necessary to manage care?

Another issue that has received less attention in this stampede to enroll Medicaid patients in managed care relates to selection bias. There are two levels of concern. First, in the short run during phased implementation, do managed care plans in general or some types of managed care plans get sicker/less-sick, more expensive/less-expensive patients than those remaining in the fee-for-service system? Answers to this question can have an obvious effect on plan viability (or create plan windfalls) during the critical ramp-up stage, as well as have an impact on total state/federal Medicaid expenditures if the residual fee-for-service patients cost more or less than expected. In states like Tennessee, where Medicaid patients were enrolled in managed care precipitously in large numbers, these issues are less important (although others are raised). But, in jurisdictions that phase in mandatory enrollment more deliberately, these problems are of greater consequence.

Second, in the longer run with full implementation of large-scale enrollment, if there are important differences in selection among plans or plan types, such conditions may create instability among plans if some experience systematic and substantial selection bias. Large differences among plans or plan types may also indicate potential inadequacy in definition of rate classes (i.e., too broad a range of utilization/expense differences among patients) that create additional problems as plans, in effect, are stimulated to engage in unhealthy efforts to obtain favorable selection by enrolling or not enrolling patients with certain characteristics.

In this study, we examine selection effects for Medicaid managed care between 1993 and 1997 in New York City. This was largely a period of suspended animation when a Section 1115 waiver authorizing mandatory enrollment for most Medicaid patients had been approved, but implementation had not yet been implemented as the terms and conditions for start-up of mandatory enrollment were defined further and “readiness” of state/local Medicaid agencies and of plans was assessed. The waiver as approved mandates managed care enrollment for most nonelderly Medicaid recipients, exempting or excluding populations