Medicaid Managed Care for New York: experience from other states, questions

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NY Medicaid

- High per person costs
- Low provider rates
- High managed care penetration
- Many plans, mainly Medicaid-only
- Expect small enrollment increase under ACA
  - Little increased state costs
- P4P program linked to HEDIS, CAHPS
  - Auto assignment, enhanced cap rates
- PACE programs
- Dual capitated managed care plans
CT Medicaid

- 1996 – MCH populations only
- Riddled with problems from the beginning
  - Little quality information, poor quality
  - Even less financial information
- Poor quality
  - 35% of children got no well-child visit in 2009
  - 5 times more likely to use an ER for care
- Finances
  - 24% rate increases 2008
  - Milliman audit found $50m overpayments 2009
- Natural experiment with ASOs found slight decrease in medical costs, with reasonable administrative costs – ASO cost less than capitation
- Transparency/FOI drove out two plans
CT Medicaid

- Secret shopper survey – 1 in 4 able to get appt
- Over time carved out behavioral health, dental, and pharmacy
- PCCM pilot implemented 2008 – enrollment microscopic
- Linked to troubled Charter Oak Program for uninsured
- Low provider participation rates (2007-2009 survey)
  - Despite relatively high payment rates
- Very little utilization tracking, and very late
- No P4P, individualized risk adjustment, HEDIS
- Little evaluation, almost no follow up to what little there was
- No regard or consequences for not meeting contractual targets
CT Medicaid

- Jan. 1 moved from 3 capitated managed care plans to ASO and fee for service
  - Non-event, remarkably smooth transition
- ASO chosen was largest MO, CHC-based plan, no other business
  - Providing risk profiles to providers and care management for high risk consumers
- Nascent PCMH program, also began Jan. 1
- CT behind most states in PCMHs across payers
- Shifting from enhanced FFS to FFS + pmpm + P4P
- Duals shared savings program in development
CT provider participation study

- Surveyed MDs before, during and after a significant rate increase (2008)
- About 50% across programs and primary/secondary care
- No change, but high turnover
- One third of practices participating now not sure if they will be in 5 years
- Surveys, focus groups, interviews with physicians, clinics, practice managers
- Interview stakeholders in other states with better participation rates
CT provider participation study

- Barriers – Rates #1
  - claims processing, customer service, communication with the state, provider credentialing, eligibility verification, prior authorization, policy changes within the programs, and communication with managed care companies, in that order

- 17% didn’t notice the rate increases
- Lots of anger, rude treatment
- Not engaged in policymaking, no transparency
- Policies not in writing, get different answers from different people
- Voice mail, calls unanswered, no idea if calling the right person
- Delayed payments
- Patients don’t understand program, look to providers
Milliman audit of cap rates

- In response to 24% rate increase
- False negotiation – need 3 plans, only got 3 bids
- Link to bringing in plans to Charter Oak
- Commissioned by State Comptroller
- DSS/Mercer would not share crunches, Milliman redid the analysis from public sources
- Raised concerns about trend and base year assumptions, discrepancies with CID filings, no targets or adjustments for quality or cost, no transparency in Medicaid line item
Recommendations

- Transparency – ensure FOI covers MCOs, full reporting to legislature
- Follow the money – independent audits
- Follow the money – track rates paid to providers
- Secret shopper study to ensure access, accuracy of panels
- Rates – follow a transparent, rational process
- Engage providers, monitor
- Engage consumers and advocates
- Track utilization, quality, patient experience of care
- Payment reform – transparent process, baby steps, engage all
Recommendations

- Standardize/harmonize payment, especially P4P, PCMH, across payers
- Monitor safety net providers
- Check MCO conflicts with commercial business
- Quality reporting with auto-trigger for penalties/incentives
  - Take it out of politics/lobbying as much as possible
- Devote resources to inform consumers
- Provider rates, processes, timeliness, information
- Written policies, online,
- Names and contact info clear for each area
Questions to ask

- First – define your goals
  - Lower ED use, increase prevention
  - Reduce rate of growth in spending
  - Expand access, provider participation

- Do we have the resources, data sources, and staff to track quality, finances, and access to care?

- How will you track provider rates, panels, grievances?

- How will you evaluate against goals?
  - Take care to keep evaluators independent

- Oversight with resources and teeth
Questions to ask

- How will you assess the impact on the safety net? The rest of the market?
- Will you track special populations separately?
  - Different evaluators?
- How will you evaluate care coordination?
- Ensure robust, real world evaluations
- How will you evaluate provider participation, winners/losers, adequacy of network?
Questions to ask

- How to tweak payment structures?
  - What will you do to even out winners/losers, unintended consequences? Political will

- Will you include consumer wellness incentives?

- What penalties and rewards are reasonable but salient?
  - Is there political will to impose penalties or deny rewards?

- How will you find problems and bright spots you aren’t looking for? Create a learning system?

- Will you risk adjust rates? How?

- How will you regulate marketing by competing plans?

- Will you coordinate with other state health care purchasing?
For more information –

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