Medicaid Managed Care in New York City: Recent Performance and Coming Challenges

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A B S T R A C T

Objectives. This study evaluated New York City's voluntary Medicaid managed care program in terms of health care use and access.

Methods. A survey of adults in Medicaid managed care and fee-for-service programs during 1996–1997 was analyzed.

Results. Responses showed significant favorable risk selection into managed care but little difference in use of health care services. Although some measures of access favored managed care, many others showed no difference between the study groups.

Conclusions. The early impact of mandatory enrollment will probably include an increase in the average risk of managed care enrollees with little change in beneficiary use and access to care. (*Am J Public Health.* 2001;91:458–460)

In the coming years, New York City will create the largest mandatory Medicaid managed care program in the nation by enrolling more than a million beneficiaries. In this report, we evaluate the performance of New York's predominantly voluntary Medicaid managed care program (which included a small mandatory demonstration in Brooklyn).

Throughout the program, managed care services have been offered by both for-profit and nonprofit network health maintenance organizations (HMOs) and prepaid health service plans, which were enabled, under New York State regulations, to help community-based providers form their own managed care plans. From 1996 to 1998, the program witnessed a number of significant changes. Most notably, premium rates fell substantially and there was considerable turnover among plans, as 7 plans exited and 14 new plans entered New York City's Medicaid managed care market.[1]

Most of New York's Medicaid beneficiaries were permitted to enroll in managed care plans during the voluntary phase, although some groups, such as those living in long-term care or psychiatric facilities, were not eligible. Those eligible included a large number of children; as a result of data limitations, however, our analysis focused only on the program's impact on nonelderly adults. In particular, we addressed the following questions: To what extent has there been favorable risk selection into Medicaid managed care? and Has Medicaid managed care had a significant impact on beneficiaries' use of and access to health care services?

Methods

We used responses from The Commonwealth Fund Survey of Health Care in New York City[2] to compare the experience of Medicaid recipients who enrolled in managed care with the experience of those who remained in fee-for-service plans. The survey was conducted by Louis Harris & Associates, Inc, between October 1996 and March 1997. Interviews were conducted in English or Spanish by telephone or face to face. Response rates for the telephone and in-person interviews were 53% and 66%, respectively. The survey oversampled low-income neighborhoods, and the data were weighted to account for differential sampling probabilities.

We used bivariate and multivariate methods in our analysis. In the multivariate analysis, we estimated equations designed to predict use and access measures based on a beneficiary's health status, socioeconomic status, demographic characteristics, and whether the beneficiary was enrolled in managed care. We calculated predicted values for the fee-for-service population and used the coefficient for our managed care variable to simulate how these predicted values would differ if the fee-for-service beneficiaries were enrolled in managed care. The result was an estimate of the marginal impact of managed care with the control variables fixed. We used a logarithmic transformation in our analysis of volume of use among respondents with at least 1 visit and applied the retransformation methods described by Manning.[3]

Results

Risk Selection

Medicaid recipients in managed care were less likely to report various health problems (Table 1). They were also younger and reported higher socioeconomic levels (according to certain measures such as poverty level, employment status, and having some college education). Furthermore, managed care enrollees were more likely to be born in the United States and less likely to be born in Puerto Rico or to report Hispanic ethnicity.

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TABLE 1—Differences in Beneficiary Characteristics Between Medicaid Fee for Service and Medicaid Managed Care: New York City, 1996–1997

Characteristic	Fee for Service (n=463), %	Managed Care (n=234), %
Health status		
Fair/poor health	46.2	31.1***
Serious illness	29.7	15.8**
Heart disease	11.0	1.7***
Asthma	17.5	16.4
Diabetes	11.3	8.9
Demographic variables		
Aged 18–25 y	20.3	32.6***
Aged 26–39 y	36.3	34.8
Aged 40–64 y	44.9	31.2***
Female	64.9	72.2
Married/with partner	18.9	34.5***
Black	35.7	48.4**
Hispanic	47.6	33.1***
Other non-White	6.8	10.3
Born in United States	53.8	63.2*
Born in Puerto Rico	16.9	9.8**
Born elsewhere	29.2	26.7
Income as a percentage of poverty level[a]		
<100	60.2	51.9
100–250	19.4	24.4
>250	4.8	8.4
Missing	15.6	15.3
Employment status		
Working full time	9.9	23.1***
Working part time	13.8	17.5
Not working	76.4	59.4***
Education		
Less than high school	46.7	43.5
High school	31.1	30.0
Some college	13.9	21.9**
College	7.9	4.7
Program participation		
Aid to Families with Dependent Children	18.6	32.5***
Supplemental Security Income	20	8.7**

[a]With missing observations excluded, difference in percentage below poverty level is significant ($P=.07$).
*$P<.1$; **$P<.05$; ***$P<.01$.

Health Care Use

There were few differences in use of health care services between the 2 groups (Table 2). One exception is that enrollment in managed care was associated with a greater volume of nonobstetric visits among those who reported at least 1 visit. The difference in the likelihood of a nonobstetric hospital admission disappeared in multivariate analyses and thus appeared to be driven by favorable selection into managed care. Although use of obstetric care among women aged 18 to 40 years appeared to be higher for managed care enrollees, the differences were not statistically significant, perhaps as a result of limited statistical power for this subgroup.

Access to Health Care

The impact of managed care on access was somewhat mixed, although it was never negative (Table 2). Managed care was associated with fewer reported denials of care and a greater likelihood of having a usual source of care. Among managed care enrollees, this usual source of care was more likely to be a clinic and less likely to be an emergency department or hospital outpatient department. However, managed care appeared to have no impact in regard to reducing difficulties in obtaining care, waiting times for appointments, or out-of-pocket costs.

Discussion

Our findings, based on a sample of nonelderly adults, suggest that New York's mandatory Medicaid managed care program will enroll medically costlier patients than it did during the voluntary phase. Given our findings on ethnicity and immigration status, the new enrollees may also be more likely to face language or cultural barriers in obtaining care.

Among the measures we examined, we generally found no association between managed care and medical care use after controlling for health status and other differences between the managed care and fee-for-service groups. It is possible that the 2 populations received a different intensity or quality of care, but our data did not allow us to make such an evaluation.

Our analysis also shows that managed care had no adverse impact on access to care, with some measures showing a positive impact (e.g., reduced likelihood of relying on emergency departments as a usual source of care). This finding is not surprising in the context of a program that assigns primary care physicians to patients. The fact that access measures other than reported usual source of care were not comparatively better under managed care suggests that the formal assignment of a primary care provider may not easily translate to a real improvement in access. Our finding that managed care enroll-

TABLE 2—Differences in Use and Access Between Medicaid Fee for Service and Medicaid Managed Care: New York City, 1996–1997

	Nonadjusted		Adjusted	
	MFFS	MMC	MFFS	MMC
At least 1 visit or admission, %				
Nonobstetric physician visit	87.0	90.5	89.6	88.2
Nonobstetric hospital admission	19.5	12.8*	17.6	20.3
Obstetric physician visit (n = 444)[a]	27.4	34.8	27.8	32.6
Obstetric admission (n = 366)[a]	6.5	12.1	6.5	9.8
Emergency room visit	49.0	48.8	49.4	50.1
Average number of visits among beneficiaries with at least 1 visit				
Nonobstetric visits (n = 604)	9.6	8.1	9.4	11.5*
Obstetric visits (n = 116)[a]	4.3	7.4*	5.3	9.0
Reported barriers to access, %				
Difficulty obtaining care	19.0	14.6	20.4	16.7
Treatments denied	17.4	10.7*	19.0	16.4*
Lack of usual source of care	16.8	7.4***	17.1	6.5***
Reported delayed access to care				
Waited more than 3 days for appointment	41.5	40.6	42.7	41.6
Went to emergency room instead of waiting for appointment	7.2	7.1	7.0	6.4
Medical treatments delayed	19.6	15.8	20.5	20.2
Usual source of care among those who had one (n = 602), %				
Doctor's office	22.3	21.4	21.9	26.5
Clinic	41.3	64.6***	44.5	54.7***
Emergency department	10.7	2.4***	10.1	3.9***
Hospital outpatient department	22.7	9.3***	20.1	12.0***
Reported out-of-pocket costs, %				
No out-of-pocket costs in past year	62.8	65.8	62.1	61.5
>$500 in out-of-pocket costs in the past year	6.7	5.4	7.5	8.9

Note. MFFS = Medicaid fee for service; MMC = Medicaid managed care.
[a]Respondents who answered "not applicable" were excluded from the analysis.
*$P < .1$; ***$P < .01$.

ment was not associated with decreased use of emergency departments underscores this possibility.

Moreover, since the time of our survey, most of the commercial HMOs with networks of private physicians have left the program, leaving mainly plans sponsored by institutional providers. With this reduced set of providers, the limited improvement in access under managed care may disappear. Thus, the experience of New York City's voluntary program raises cautions about the usefulness of Medicaid managed care in regard to improving access for adult beneficiaries. □

Contributors

D. DeLia helped conceptualize the study, performed the data analysis, and led the writing of the manuscript. J. C. Cantor led the early study design and contributed to the writing of the manuscript. D. Sandman managed the design and implementation of the survey instrument, contributed to the early study design, and contributed to the writing of the manuscript.

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