ACKOFF FELLOWSHIP
APPLICATION FORM

Deadline: March 3, 2013
(midnight)

Name: Boris Vabson

How did you learn about the Ackoff Fellowship:

_____Ad in DP ___Ad in Almanac X E-mail __Other (specify) _____

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Department/University of Pennsylvania: Business Economics and Public Policy

Faculty Advisor Name: Mark G. Duggan E-mail mduggan@wharton.upenn.edu

Faculty Department: Business Economics and Public Policy

Project Title:
What Managed Care Does and How It Does It: Evidence from New York and Texas Medicaid

Amount of Request: $ 4,000

Other sources of Support for your research:

Travel $_____

Grants $_____Other (Specify) $7,560 (pending department/fellowship requests)

Research Goals:

Over the past 20 years, state Medicaid programs have contracted out an increasing share of their Medicaid caseloads to private managed care plans, with such plans currently covering about 60% of Medicaid recipients. Contracting out of Medicaid provision was initiated in an attempt at cost and quality improvements, relative to direct government provision. However, the magnitude of efficiency gains from privatized Medicaid, and the share of these gains captured by governments as well as firms, has been subject to relatively limited empirical examination (Duggan 2000, Aizer 2007, Duggan et al 2011). This lack of empirical investigation is unfortunate, given Medicaid's fiscal as well as social significance, with current expenditure levels of over $400 billion a year and an enrollment base of over 60 million low-income Americans (Smith, 2012).

I will make use of novel Medicaid claims data for New York and Texas, covering managed care as well as fee-for-service encounters, throughout periods of Medicaid managed care expansion in these states. Mine will be the first academic study to utilize internal Medicaid managed care data, which will allow for analyses that were previously infeasible, including a rigorous examination of cost and quality differences between the two types of Medicaid provision. Altogether, I will estimate the overall welfare impact of Medicaid's contracting out, as well as how these welfare gains/losses are ultimately distributed among governments, consumers, and firms. I plan to identify the mechanisms through which these gains/losses are produced, either through changes in prices, quantity of treatment, quality of providers, or levels of preventative care. In addition, I will examine possible cost differentials, based on how governments' managed care expenditures for a given enrollee compared to what they spent under FFS. Finally, I will consider possible heterogeneous impacts of managed care across Medicaid eligibility categories (children, disabled, etc), initial levels of health, plan types, and care settings.

Altogether, the results of this study could significantly inform policymaking, could identify the extent of public benefits from managed care, and the extent to which these benefits might be limited from capture by private firms (potentially by spending much less on enrollees than they receive from governments). As such, this paper could provide insight on whether past complications with private provision of public insurance have been the result of suboptimal contracting between governments and insurers, as opposed to inherent shortcomings of managed care provision.

Literature Review:

Governments have previously contracted out numerous services, such as construction and defense provision, with the aim of improved quality and cost. For Medicaid, private provision could result in cost savings through lower effective prices, as a result of bargaining and selective contracting between insurers and providers (Cutler et al, 2000). In theory, cost savings could also result from overall reductions in quantity of care, either through more effective preventative care, a shift to less intensive procedures, increased cost-sharing, as well as potential rationing of treatments. In addition, cost and quality improvements could be produced through competition among various private plans.

Existing literature suggest that that Medicaid managed care expansions are, in fact, associated

with increased Medicaid spending, although the spending increase has been less pronounced in states with relatively high Medicaid reimbursement. In addition, the literature provides little indication that Medicaid managed care yields quality improvements or improved patient outcomes (Duggan 2004, Aizer et al 2007, Duggan et al 2011). At least some of this increased spending under managed care has been shown to be the result of suboptimal contracting, given ineffective rate setting, insufficient competition, and ineffective risk-adjustment that has allowed for cream skimming (Brown et al, 2012). However, even under optimal contracting, it is unclear how much quality or cost improvement would result from transition to privatized Medicaid.

Research Methods:

I will examine the impact of Medicaid managed care in New York and Texas throughout the 1999-2009 period, and will investigate how utilization levels, provider characteristics, medical pricing levels, health outcomes, and overall expenditure levels differed across Medicaid FFS and private managed care. To measure utilization levels, I will examine rates of hospitalization, lengths of stay conditional on hospitalization, and other metrics of treatment quantity. To measure quality of treatment and outcomes, I will consider rates of preventable hospitalizations (particularly for chronic conditions), along with mortality rates. I will do all of this using a set of Medicaid claims and enrollment data, which will allow me to longitudinally track Medicaid recipients and examine differences in their experiences under managed care, relative to fee for service.

Comparisons of managed care and fee-for-service plans are complicated by differential selection of enrollees across plans (Morrisey et al, 2012). It is necessary, therefore, to disentangle the effects of managed care from accompanying effects of patient composition. To achieve identification and isolate the effects of managed care implementation, I will exploit time and county-level geographic variation in the implementation of New York and Texas's managed care mandates. These mandates required certain populations to transition from fee-for-service Medicaid into Medicaid managed care, in areas where managed care enrollment was previously voluntary. Further, I will exploit variation in the Medicaid subpopulations affected by these mandates. By focusing on the subset that involuntarily enrolled in Medicaid managed care, and comparing their fee-for-service and managed care experiences, I will be able to mitigate for possible confounding factors, and focus in on changes that come directly as a result of managed care enrollment.

Reason for Requesting Funding:

I am requesting funding towards the purchase of data from the Centers of Medicare & Medicaid Services. This data, particularly Medicaid managed care claims data for New York and Texas, is vital to the research project. Claims data on Medicaid managed care has never been used in academic research, and will allow for analyses that were previously infeasible.

Budget Plan:

The requested funds will be allocated, in their entirety, towards the purchase of data. The data to be purchased includes Medicaid Fee-For-Service and managed care hospital claims data, as well as Medicaid enrollment data, for the following states and years: New York State for 1999-2009, Texas for 2004-2009. The periods I have chosen coincide with the timing of Medicaid managed care expansions within those states as well as the availability of relevant data.

The cost of the Medicaid enrollment data is $420 per state per year, while the cost of the Medicaid Fee for Service & managed care hospital claims data is $260 per state, per year. All of this is payable to the Centers for Medicare and Medicaid Services. The data's total cumulative cost, therefore, is $11,560.

I am requesting $4,000 in funding through the Ackoff Fellowship to help cover this data expense. I am requesting funds through my department as well as through other fellowships, such as the 'Trio' Pilot Competition, to defray remaining $7,560 in data expenses.

References:

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Cutler, D., McClellan, M., and Newhouse, J. "How Does Managed Care Do It?" *RAND Journal of Economics* 2000, 31(3), 526-548.

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