Impact of Privatization on Health Outcomes in Medicaid

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Introduction to Medicaid Privatization and Cancer Outcomes

This presentation aims to explore the impact of **Medicaid privatization** on cancer care and outcomes. Understanding this association is crucial for improving patient care and informing policy decisions.

Objectives

Assess the implications of Medicaid privatization on cancer patient outcomes Discuss research findings and their relevance to healthcare systems Encourage legislative action to enhance patient care

Medicaid Privatization Timeline

- **1965:** Medicaid established for low-income individuals, state-administered with federal oversight.
- **1970s–1980s:** Managed care introduced to control costs; private Managed Care Organizations (MCOs) contracted by states.
- **1990s–2000s:** Managed care expanded; by 2010, 70% of beneficiaries enrolled in private MCOs. ACA expanded Medicaid increasing number of Americans enrolled in private MCOs through Medicaid.
- **2012:** Connecticut returned to state-run Medicaid due to service denial concerns in private models.

Key Themes in Privatization

- **Cost Containment:** Privatization aims to reduce state and federal spending by leveraging competition and administrative efficiency
- **Access and Quality Concerns:** Critics argue that privatized systems can lead to service denials, administrative hurdles, and inconsistent quality. Supporters claim they offer innovation and flexibility
- **Data Transparency:** A persistent challenge with privatized Medicaid and Medicare systems is limited data availability on health outcomes, complicating comprehensive evaluations of their efficacy

Michigan Experience

Examining Michigan's experience offers insights into the challenges faced under privatized Medicaid.

Providers serving Medicaid populations may encounter delays, especially for services affecting vulnerable or complex patients

- Delays and denials of care for cancer patients\
  - Timelines for Prior Authorization approvals and denials for cancer typically 2 weeks
- Increased administrative barriers impacting timely treatment
- Delays disproportionately affect vulnerable populations with fewer resources to navigate appeals.

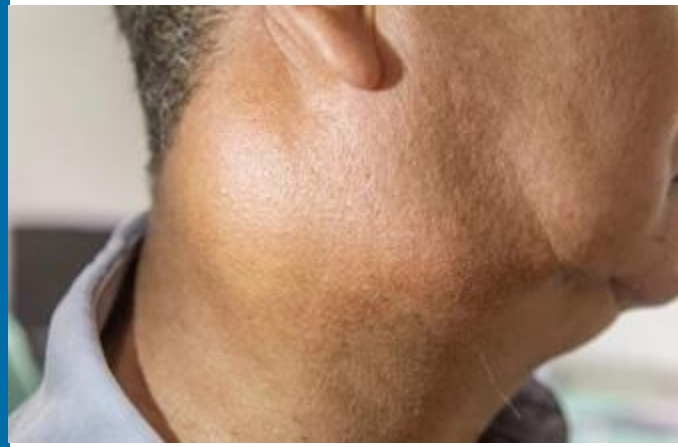
Michigan Experience

Patient Presentation:

- **Initial Symptom:** Neck mass (Level II)
- **Diagnosis Pathway:**
  1. **Initial Evaluation:**
     - **CT Neck Ordered:** Delayed 2 weeks due to prior authorization (PA)
     - **Total PA Process:** 3 weeks
  2. **Results:**
     - **Findings:** 4 cm Level II neck mass
     - **Referral to Specialist:** 2-week delay for processing

Impacts:

- **Delayed Diagnosis:** 5 weeks from initial presentation to specialist evaluation
- **Potential Consequences:** Disease progression during waiting period



Michigan Experience

Evaluation & Imaging:

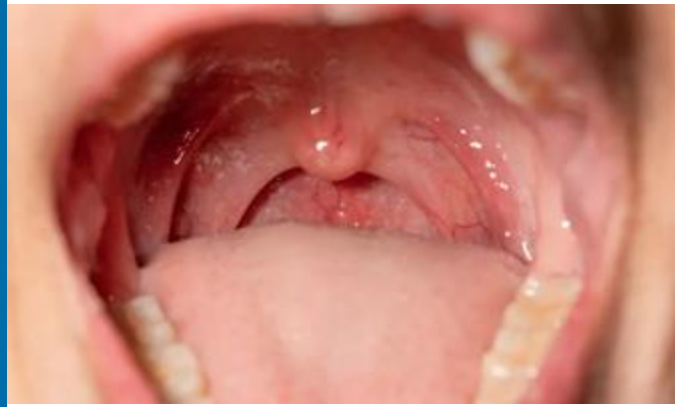
- **Neck Mass Biopsy:** Performed upon referral
- **PET/CT Ordered:**
    - **Prior Authorization Delay:** 2 weeks
    - **Total Wait:** 3 weeks before PET/CT completed
    - **Findings:** No obvious primary

Examination under anesthesia for primary and tonsillectomy

- **Prior Authorization Delay:** 2 weeks
- **Total Wait:** 3 weeks before OR scheduled
- **Findings:** 5mm primary found **in the tonsil**

Clinical Course:

- **Tumor Board Discussion:** Chemoradiation recommended
- **Simulation Scan:** Disease upstaged after total of 11 week delay
    - **New Finding:** Bilateral lymph node involvement



Research Methodology

Study Overview

Our study assessed the relationship between Medicaid privatization and cancer outcomes using a robust methodology.

Data Sources

Analyzed data from the **SEER Program** (2007-2016) focusing on **Connecticut** (public) and **New Jersey** (private) Medicaid patients.

Cohort: 29,328 patients (Connecticut: 14,424; New Jersey: 14,904)

Cancer Types Included

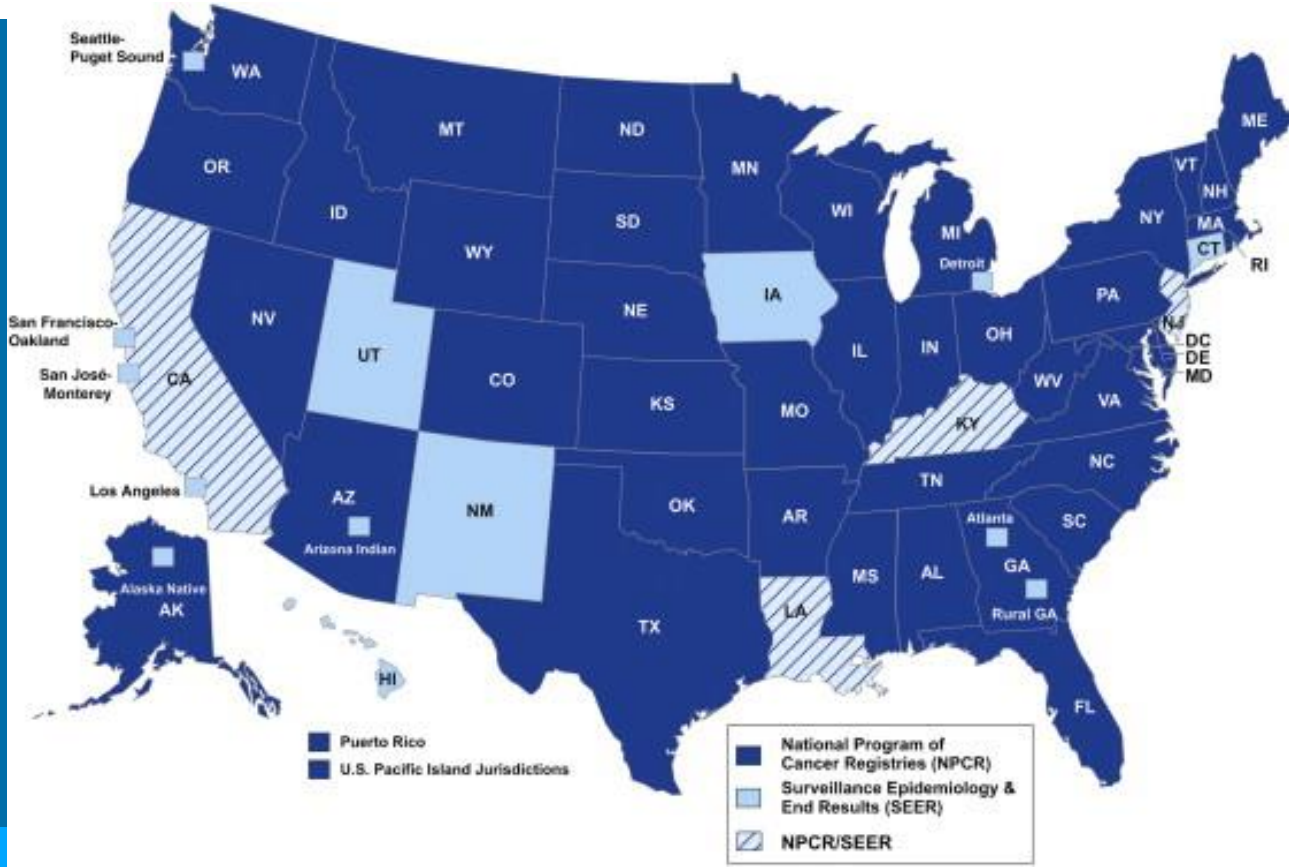
Included 10 common solid cancers: breast, lung, colorectal, prostate, kidney, bladder, cervix, uterus, head and neck, and melanoma.

Research Methodology

SEER Program

The **Surveillance, Epidemiology, and End Results (SEER) Program** is a premier source of cancer statistics in the United States, operated by the **National Cancer Institute (NCI)**

SEER collects data on cancer incidence, survival, prevalence, and mortality from population-based cancer registries across the U.S.



Research Findings

January 1 2012
Connecticut transitions to publicly administered Medicaid

Statistical Approach

Difference-in-differences analysis

Comparison of early-stage diagnoses and survival rates

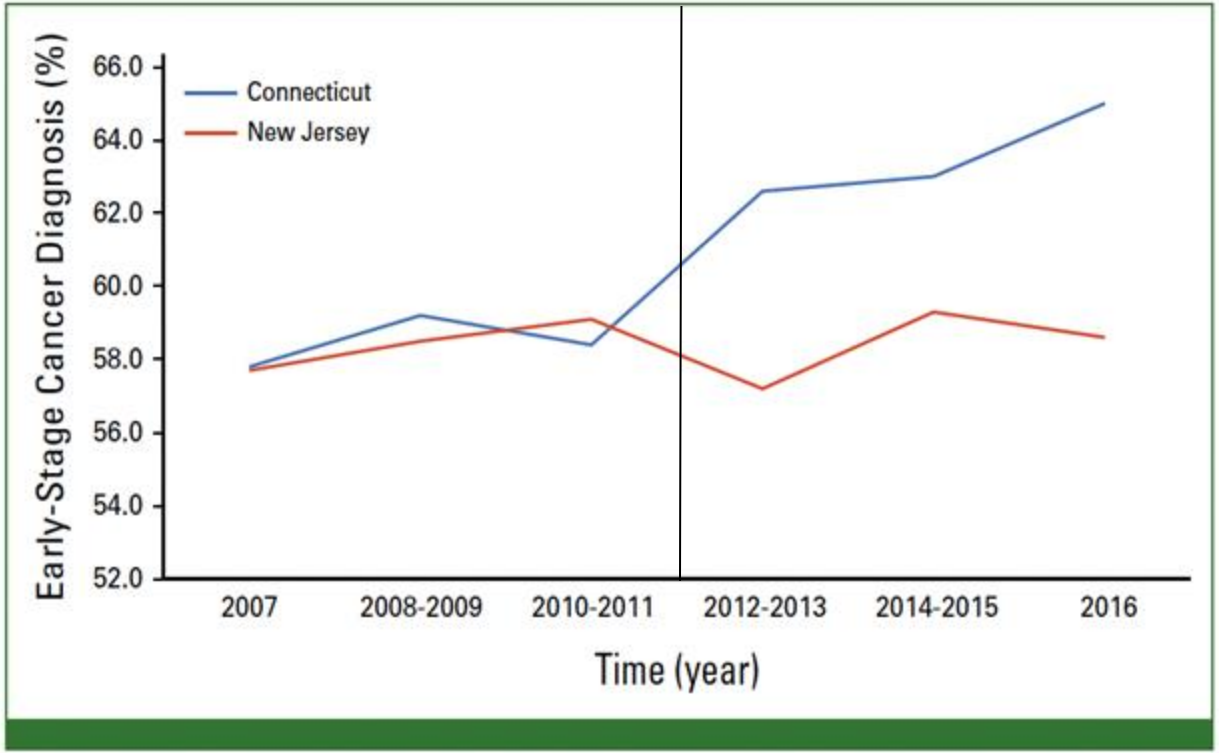


FIG 1. Early-stage change diagnoses over time.

Research Findings

TABLE 2. Difference-In-Differences Analysis of Study Cohort

Time Period	New Jersey Medicaid Patients (% early-stage diagnosis)	Connecticut Medicaid Patients (% early-stage diagnosis)
2007-2011	58.6	58.6
2012-2016	58.6	63.3
Absolute change	0.0	+4.7
DID unadjusted (95% CI)	NA	**+4.7 (+2.4 to +7.0)**
DID adjusted (95% CI)[a]	NA	**+4.0 (+1.7 to +6.2)**

NOTE. Bolded are statistically significant values ($P < .001$).
Abbreviations: DID, difference-in-differences; NA, not applicable.
[a]Adjusted for time period, state, age, sex, race, primary site, county, education level, and county median household income.

Research Findings

Survival Outcomes

8% lower risk of mortality in Connecticut

TABLE 3. Cox Proportional Hazards Analysis of the Risk of Mortality by Demographic, Oncologic, and Socioeconomic Status

Variable	Unadjusted HR (95% CI)	Adjusted HR (95% CI)[a]
Intervention status		
No intervention	1.00 (reference)	1.00 (reference)
Intervention	**0.84 (0.80 to 0.88)**	**0.92 (0.85 to 0.99)**
Time period		
Pre (2007-2011)	1.00 (reference)	1.00 (reference)
Post (2012-2016)	**0.81 (0.78 to 0.85)**	**0.90 (0.85 to 0.95)**
State		
New Jersey	1.00 (reference)	1.00 (reference)
Connecticut	**0.90 (0.87 to 0.94)**	**0.91 (0.86 to 0.96)**

Other Studies of Health Outcomes in Privatized Medicaid

Studies evaluating the impact of MCOs on mortality and morbidity show mixed results:

- Improved Utilization, No Mortality Benefit:

  Privatized Medicaid models typically reduce hospitalizations and emergency department (ED) visits, as seen in studies of large-scale state MMC transitions (1, 2].

  However, mortality outcomes show limited or no improvement. For instance, a study of California's mandatory enrollment of seniors and persons with disabilities into MMC found increased mortality for patients with high pre-existing medical needs, suggesting adverse effects for vulnerable populations (3).

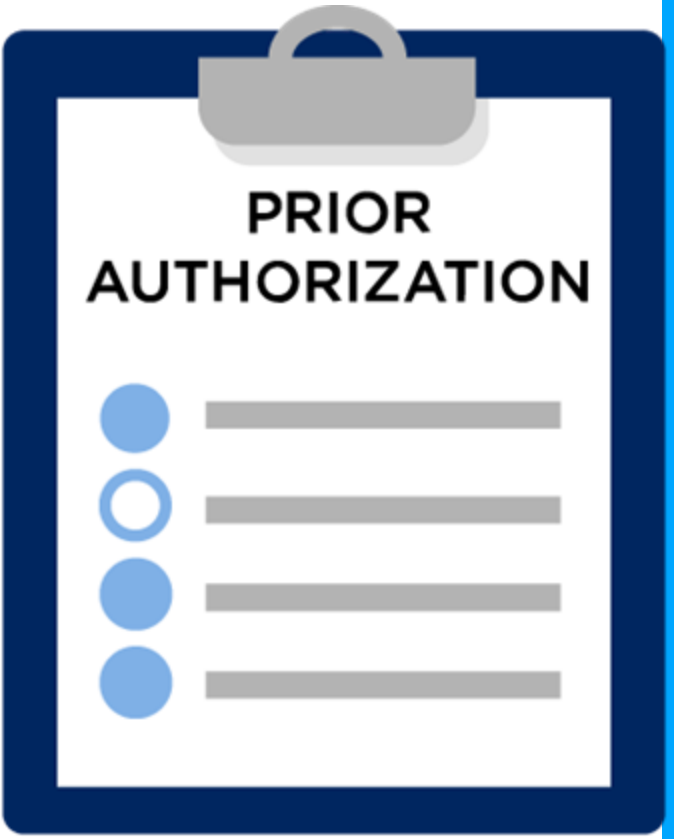
1. Macambira et al., SSRN. 2022; 2. Layton et al., Political Economy. 2019; 3. Duggan et al., NBER. 2021.

Other Studies of Disparities and Equity in Medicaid

Racial and socioeconomic disparities remain largely unaddressed under MCOs:

- Mixed Impacts on Racial Disparities: While some evidence suggests MCOs can reduce utilization disparities (e.g., higher outpatient visits among racial minorities in Kentucky's Passport MCOs program) (1), other studies report no significant reductions in disparities or, in some cases, worsening outcomes for minority populations (2, 3).
- Dual-Eligible Populations: Integrated care models for dual-eligible individuals (those enrolled in both Medicaid and Medicare) show limited improvements in reducing fragmented care or meeting the unique needs of this high-spending group (4, 5).

1. Marton et al., Health Serv Res 2015; 2. Gorges, Innov in Aging 2019; 3. Greenberg et al., J Health Care Poor Underserved 2003; 4. Jung et al., Health Affairs 2015; 5. Burton et al.,J Am Geriatric Soc. 2002



Implications for Patient Care

The findings highlight critical implications for cancer patient care under Medicaid privatization.

- **Access to Services**: Public administration may enhance access to necessary screenings and treatments
- **Treatment Delays**: Privatization often leads to increased healthcare utilization oversight which can create delays in care, negatively impacting patient outcomes
- **Overall Outcomes**: Earlier diagnoses and improved survival rates are associated with public Medicaid models

Legislative Considerations

The research findings present important policy implications for legislators.

- Consider transitioning from privatized to publicly administered Medicaid systems
- Ensure that Medicaid policies prioritize patient access to cancer care
- Advocate for legislative measures that support equitable healthcare for Medicaid patients

Recap of Key Points

To summarize, the presentation highlighted the significant impact of Medicaid privatization on cancer outcomes.

- Public Medicaid administration is associated with better cancer outcomes
- Connecticut's model offers valuable insights for improving Medicaid nationwide
- Urgent need for data-driven Medicaid policy decisions
- Improved data collection standards, enabling comparative analyses that account for differences in social determinants of health.
- Targeted interventions for high-risk populations, such as dual eligibles or individuals with chronic illnesses
- Enhanced regulatory oversight needed to ensure network adequacy and equitable access for patients in MCO programs

Questions and Answers

Now, I would like to open the floor for questions. Please feel free to ask for clarifications or engage in further discussion about the impacts of Medicaid privatization on cancer outcomes.