

The Medicaid Managed Care Program

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Editors' Introduction

In the 1990s, as insurance companies and employers began to rely on managed care as a method for controlling health care costs, state governments followed suit by adopting managed care for their Medicaid programs. Medicaid pays for medical and long-term care for more than fifty million low-income Americans. It is financed by both the federal and state governments and is administered by the states. The task of adapting managed care to Medicaid was daunting, and in 1995 the Foundation developed an initiative—the *Medicaid Managed Care Program*—to help state governments, health plans, and consumers improve their use of managed care. The Foundation's staff felt that managed care represented an opportunity to both reduce the cost and improve the quality of health services delivered to low-income Americans.

This chapter, written by the program's chief evaluator, Marsha R. Gold, and her colleagues at Mathematica Policy Research, describes the initiative and, drawing on the evaluation, offers an assessment of it. The authors discuss the various types of interventions used by the program to serve its constituencies, especially state governments and health plans. They also examine how the program, and the Center for Health Care Strategies where it is located, have evolved over the years.

Medicaid today is in crisis, devouring state budgets across the nation. Covering one out of every six Americans, the program costs \$300 billion a year, having recently surpassed Medicare. It pays for some 60 percent of the nation's nursing home costs. In some states, Medicaid expenses, which have risen 63 percent in the past five years, account for a third of the budget. Even as the federal government threatens to reduce its contribution to the program, states are trying to find ways to slash their Medicaid budgets. Tennessee, for example, plans to cut off benefits for 320,000 Medicaid recipients in 2006.¹ Even though an initiative such as the Medicaid Managed Care Program doesn't address the root fiscal problems affecting Medicaid, its promise to help states buy higher-quality health services at lower cost and to assist health plans to provide better care for Medicaid patients bears careful watching.

1. Sara Lueck, "Surging Costs for Medicaid Ravage State, Federal Budgets." *Wall Street Journal*, Feb. 7, 2005, p. 1.

Medicaid, the main source of health insurance for a range of low-income, disabled, and seriously ill people, accounts for 17 percent of the nation's personal health spending.¹ More than fifty million people are enrolled in the program, including thirty-eight million low-income children and parents, and twelve million elderly and disabled people, half of whom also qualify for Medicare. The elderly and the disabled make up 25 percent of Medicaid beneficiaries but account for 70 percent of its spending. Although Medicaid is a national program, it is administered by the states; eligibility, benefits, and other program features vary substantially from state to state.

Enacted in 1965, Medicaid has been based largely on traditional fee-for-service insurance arrangements with health care providers; that is, providers willing to participate in the program were paid fees for the services they rendered. Starting in the 1970s, however, a few states experimented with offering Medicaid beneficiaries the option of enrolling in private managed care plans, especially health maintenance organizations, or HMOs.² For a monthly payment per person enrolled in the HMO (the "capitation rate"), the plans took responsibility for providing or arranging medical care covered under the state's program. States also pursued other managed care arrangements, such as primary care case management, which involves paying physicians a small monthly fee (in addition to fee-for-service) to coordinate care for their Medicaid patients.

In the 1990s, more states began to use managed care arrangements and to make enrollment in them mandatory for some categories of beneficiaries. Between 1990 and 1995, the percentage of Medicaid beneficiaries enrolled in managed care increased from 9 to 29 percent nationwide.³ By 2003, some 60 percent of Medicaid beneficiaries nationwide were in managed care arrangements, primarily HMOs. Although states varied substantially in their use of managed care, thirty-four states and the District of Columbia had at least 25 percent of their Medicaid beneficiaries enrolled in HMOs in 2003 and nine had 75 percent or more. A higher percentage of children and families than disabled or elderly people were enrolled in HMOs.⁴ Managed care remains a key part of Medicaid today in many states, even though some states experienced highly visible setbacks when health plans withdrew from their program, often because of conflicts over the adequacy of payment.⁵

Although state policy-makers wanted to save money by moving Medicaid beneficiaries to managed care, they also hoped to improve the access to, and the quality of, care. In many states, the supply of physicians practicing in areas where Medicaid beneficiaries lived was limited, and the low fees that Medicaid paid to physicians restricted the number of those willing to participate in the program.⁶ This led Medicaid enrollees to seek care in emergency rooms, hospital outpatient departments, and subsidized clinics instead of physicians' offices. Policy-makers grew concerned that the lack of a medical provider to coordinate care would diminish the quality of services received by Medicaid beneficiaries and would ultimately lead to higher costs. They were particularly concerned about the quality of care for individuals with complex conditions—chronic illnesses, mental impairments, substance addictions—who required services from a range of providers.⁷

The Medicaid Managed Care Program:

History and Evolution

This environment of expanding Medicaid managed care and concern about quality spawned the Medicaid Managed Care Program, or MMCP, in the mid-1990s. Seeking to capitalize on the growing attention being given to Medicaid managed care, the Robert Wood Johnson Foundation established the MMCP in 1995 with the goal of improving access to and quality of care for Medicaid beneficiaries, particularly for those with chronic illness or disabilities.⁸ (It reauthorized the program in 1999 and again in 2002. All told, the Foundation has committed \$57 million to support the MMCP through mid-2006.) Led by a former Foundation staff member, Stephen Somers, the MMCP was housed in a new organization, the Center for Health Care Strategies, created especially to manage it.

Initial Program Structure

Initially, the Center for Health Care Strategies and the MMCP were essentially indistinguishable; the MMCP accounted for almost all the Center's funding. The MMCP's goals, profiled in its first call for proposals in 1996, were to assist states "in the design and evaluation of their Medicaid managed care policies" and assist health care providers and consumers in "the design, demonstration, and evaluation of new models of managed care for enrollees with chronic health and social problems." From the beginning, the MMCP awarded two main types of grants:

- *Model Demonstration Project Grants.* These grants provided up to \$500,000 over a three-year period to support the development of new models to manage care for people with disabilities, chronic illness, and other complex care needs.⁹ Typically awarded to states and health plans, the grants were intended to support innovative demonstration projects. In 1997, the program also authorized initial planning grants of up to \$100,000. These enabled grantees to explore the feasibility of their proposal or to refine their plans before the MMCP decided whether to fund a full demonstration.
- *Best Practice or Policy Study Grants.* These grants provided up to \$100,000 to state agencies, health plans, consumer organizations, health services researchers, and policy analysts. Best practice grants were awarded to identify, develop, and test innovative practices to improve the delivery of Medicaid managed care. Policy study grants documented best practices in management and operations of Medicaid managed care or provided analysis of market trends and policies that affect the implementation and outcomes of Medicaid managed care.

Between 1995 and 2002, twenty-five grants were awarded under the program for model development projects and 154 smaller grants for best practices or policy studies, though the former, by virtue of their size, accounted for a disproportionate amount of program spending. One early demonstration grant, awarded to the Delaware Department of Health and Social Services, went to developing a comprehensive Medicaid managed care model for elderly and physically disabled people and to designing a program that would provide managed long-term care for people with severe and persistent mental illness, substance abuse, or both. Under another model demonstration grant, the Washington Department of Social and Health Services selected Clark County to pilot a Medicaid managed care program for Supplemental Security Income recipients. As an example of an early best practice grant, the University of California, San Diego, produced a manual on risk-adjusted rate setting (that is, setting Medicaid payment schedules to providers that reflect the diagnosis and severity of illness of

their patients). The chapter appendix provides examples of early model demonstration and best practice grants.

Both the Foundation and the Center for Health Care Strategies saw the model demonstration grants as particularly important, since they tested new methods of delivering care that could be shared broadly and help move the field. The Foundation gave the MMCP considerable discretion to make grants, including authority to make grants of up to \$500,000 on its own. However, from the beginning, the MMCP found it difficult to attract strong proposals for model demonstration projects. Only twenty-six applications were received in response to the initial call for proposals in 1996, and only one of these was funded (though four additional proposals were awarded planning grants and three ultimately received funding for full-scale demonstrations).

As a consequence, in early 1997, the leadership of the Center for Health Care Strategies began to feel that the grantmaking strategy alone was not really an effective way to meet the program's objectives: the process was too passive, it relied on the strength of the applicants, and it generated weak proposals. Over the next few years, center staff members began to engage states more actively by focusing on assessments of their readiness for managed care and providing technical assistance.

Concurrently, the Foundation was addressing the same concerns as it considered whether to renew the grant. An internal Foundation assessment of the MMCP in late 1998 found that although the program had produced useful products and had earned respect as a neutral convener, Medicaid managed care had progressed less rapidly than envisioned (particularly for the most vulnerable Medicaid beneficiaries—those with chronic illnesses and disabilities). The fact that most states' Medicaid managed care initiatives targeted families and children and not those qualifying for Medicaid because of their disabilities or chronic conditions—the initial focus of the MMCP—was proving to be a major limitation to the program model. The Foundation's analysis concluded that the MMCP could be strengthened with a more clearly defined and more effectively communicated and executed strategy.

Restructuring the Medicaid Managed Care Program

In reauthorizing the program for five years in 1999, the Robert Wood Johnson Foundation committed \$13 million in additional funds for grants and, for the first time, \$12 million for technical assistance. Under the new authorization, the MMCP shifted its priorities considerably.

- First, as a complement to making grants to states and others, it added an assistance strategy that involved primarily technical support. Over time, grant funds were increasingly linked to assistance and targeted in priority areas.
- Second, rather than targeting Medicaid managed care work to improve services for disabled and chronically ill Medicaid recipients, the MMCP focused more broadly on improving the quality of Medicaid managed care for all recipients by strengthening state governments' capacity to purchase quality services, by improving health plans' ability to measure and report on the quality of services, and, to a lesser extent, by helping consumers navigate the system.

Under the new approach, the MMCP can be viewed as helping state Medicaid programs and health plans pursue practices analogous to those of large private purchasers. The MMCP uses many of the same tools as others working on quality improvement—in particular, tools designed to help purchasers measure and reward good performance and encourage health plans to focus on quality. In the commercial sector, large employers lead the way, often requiring their managed care plans to be accredited by the National Committee for Quality Assurance, or NCQA. This requirement provides strong incentives for such plans to pursue quality improvement—incentives that are lacking for health plans that don't have an extensive commercial base, even though such plans have carved out a growing share of the Medicaid market. Since NCQA accreditation is expensive and typically geared to large employers, states rarely require it, but instead develop their own, somewhat parallel, series of quality improvement requirements for health plans in Medicaid.¹⁰

In 1999, the MMCP began to restructure its activities. It defined three core audiences—states, health plans, and consumers—and four core organizing principles around which its work would be structured:

- *Informed purchasing* to promote the purchasing of high-quality and cost-effective managed care services by states.
- *Managed care best practices* to support quality improvements in clinical and administrative practices in managed care offered by participating health plans.
- *Consumer action* to promote the ability of consumers to navigate health care delivery systems and to institutionalize a role for them in the design, implementation, and monitoring of publicly financed managed care.
- *Integrated systems of care* to promote the integration of services and funding across public agencies, managed care organizations, and providers. (This was later dropped as a distinct element, because the Center for Health Care Strategies concluded that such concerns were relevant to all elements; the change allowed the MMCP to align its core principles with each of its core audiences.)

Most of the funding provided under the MMCP's reauthorization was used to develop initiatives built around each of the three main audiences identified by the Center for Health Care Strategies: the Purchasing Institutes for states; the Best Clinical and Administrative Practices, BCAP, Initiative for health plans; and the Consumer Action Agenda for consumer groups.

- *Purchasing Institutes* are two- to three-day workshops that aim at helping Medicaid staff members improve their skills in buying health services through Medicaid managed care. Teams of senior staff members from different states attend. Institutes vary in focus and sophistication, but a basic one might include sessions on core skill areas like the basics of managed care purchasing; setting capitation rates; assessing the adequacy of provider networks; and monitoring access, quality, and performance. After each Institute, the participants are expected to return home and work to generate improvements in the areas covered at the Purchasing Institute. Since 2000, the MMCP has sponsored five basic Purchasing Institutes. Two additional Purchasing Institutes involving more intensive work over several meetings were convened specifically to help states monitor and reward managed care performance.

- *The Best Clinical and Administrative Practices Initiative* is designed to enhance the ability of Medicaid health plans to provide quality care within budgetary limits. Each BCAP work group involves staff members from ten to twelve health plans who get together in three or four structured meetings over nine to twelve months and work on improvements in a given clinical or administrative area, such as asthma or care for adults with chronic illness and disability. This is followed by an additional year of telephonic and other support from the Center for Health Care Strategies' staff. For example, work on asthma can involve developing registries of patients with asthmatic conditions, identifying those at particularly high risk, and doing outreach to help monitor and stabilize patients. The lessons from these groups are fed back to health plans in a variety of forms, including toolkits and meetings, such as the MMCP's periodic "Quality Summits," which are essentially interactive conferences on quality issues for health plans. The MMCP has held five BCAPs on improving birth outcomes, preventive care for children, asthma, children with special needs, and adults with chronic illness and disability. The approach is not unlike that of the Institute for Healthcare Improvement in its work with providers to improve care.¹¹
- *The Consumer Action Agenda* aims at helping consumers navigate and establish a formal role in Medicaid and similar managed care systems. Small grants awarded to consumer and family-based organizations have been the primary vehicle for advancing the Consumer Action Agenda. Two rounds of grants have been awarded. In 2001, MMCP provided up to \$25,000 each to nineteen grantees, and the Robert Wood Johnson Foundation supplemented these awards for ten grantees under its *Covering Kids & Families* initiative. In 2002, the MMCP provided ten grants of up to \$50,000 each to consumer organizations representing people with disabilities and chronic illness. Activities funded as part of consumer action grants include developing materials and convening educational seminars to help consumers learn how to navigate Medicaid managed care; training consumers in how to participate in the design or monitoring of these systems; and developing peer support services to allow consumers to help one another gain appropriate access to care.

The MMCP also convenes periodic meetings of the Managed Care Solutions Forum (formerly called the Managed Care Pricing Forum) to bring together stakeholders from all sectors to discuss emerging issues, identify areas that need analysis, and provide feedback on reports, proposals, and policy initiatives. An early forum involved issues of setting capitation rates and a later one involved issues associated with purchasing pharmaceuticals.

To provide an early assessment on the shift in strategy, the Robert Wood Johnson Foundation asked Mathematica Policy Research to review documents and interview participants in the programs. Mathematica's report, submitted in 2001, found strong support for the programs from the MMCP's major constituencies, especially from Medicaid staff members who had the longest history with the Center for Health Care Strategies. Among all constituencies, the perception was that the MMCP was providing an important product that was not otherwise available. Particularly attractive to participants were the interactive forums and their focus on operations; they liked the fact that forums were focused on specific topics, strong in content, and small in scale. The report noted, however, that it was too soon to determine the ultimate effects of the new strategies and that future success would be likely to require developing a more integrated strategy that would create synergies among activities—grants and technical assistance, for instance.

Maturation and Diversification

Building on the Mathematica assessment, in 2001, the Robert Wood Johnson Foundation authorized \$10 million in new funds to continue the program through June 2004, subsequently extended two years to December 2006. The new funds were integrated with about \$20 million remaining from previous grants. Viewing grantmaking, technical assistance, and publications as related ways of achieving its goals, the MMCP gave priority in its grantmaking to states and health plans that participated in Purchasing Institutes or BCAP work groups. The Center for Health Care Strategies, which has the authority to vary the allocation of its MMCP funds between technical assistance and grants, over time has shifted more of its resources to the former. The MMCP has replaced its general grant solicitations with more targeted ones, aimed at those working with children with special needs, managed behavioral and general health care coordination, and managed long-term care, among others. Increasingly, the MMCP prefers small grants with substantial in-kind contributions.

As the MMCP has matured, it has sought to leverage the knowledge, respect, and products it had developed to attract other sources of financial support. For example, both the California HealthCare Foundation and the David and Lucile Packard Foundation have supported BCAP collaboratives in California and New York. This funding has allowed the Center for Health Care Strategies to apply the BCAP approach in more settings and has also provided support to test out modifications to the model. In addition, the Center is developing a new Medicaid Disease Management Initiative, jointly funded by Kaiser Permanente and the Robert Wood Johnson Foundation, which focuses on improving care delivery for Medicaid recipients with multiple chronic conditions.

What the MMCP Has Accomplished

In 2004, Mathematica completed a second evaluation of the MMCP—this time of the program as it operated between 2000 and 2003, a period when the MMCP was largely providing technical support to improve Medicaid managed care, with selected use of grants to support that objective. The MMCP might, for example, use grant funds to help states develop a measurement system that supports a new strategy developed in the Purchasing Institute; or it might invite a health plan with a grant that was focused on quality improvement in a given area to participate in a BCAP in the same area.

The evaluation distinguished the *reach* of the MMCP's activities from their *outcomes*, each of which is discussed below. Overall, the evaluation found that the program was reaching large sectors of its intended audiences with products that were well regarded, and that the support provided by the MMCP has led to concrete changes in the way some states and health plans deliver Medicaid managed care.

Program Reach, Participation, and Reputation

Reach defines the extent to which activities under the MMCP are known to the core audiences it seeks to help, the breadth and the intensity of participation by these audiences, and the opinions of core audiences on the quality and the value of the support they receive from the MMCP.

Information on these issues was gathered through surveys of the MMCP's core audiences, whether or not they participate in the program. Mathematica conducted telephone interviews with Medicaid

directors in each state and surveyed key senior staff members involved in the states' MMCP activities, the medical directors (or head of clinical quality) of all health plans participating in Medicaid nationwide, and a range of consumer groups with a potential interest in Medicaid managed care. It also identified and surveyed other stakeholders, including the staff involved in Medicaid managed care in the federal government (especially in the Centers for Medicare & Medicaid Services), public and private policy groups and associations, and the research community. The response rate was at least 85 percent for each group surveyed.

The survey findings were generally positive. The core audiences and stakeholders surveyed were typically aware of the Center for Health Care Strategies and its work on Medicaid managed care. Although the respondents also relied on other sources for information, they felt that the MMCP provided a unique resource that focused on operational concerns in ways that were unavailable elsewhere. For example, state Medicaid directors cited as strengths the Center's "connections and competence" and its "breadth of experience," its willingness "to try different things... to take risks and be demanding about what they [expect]," and its "institutional memory" and capacity for "being able to reach out... and dealing with all 50 states, or a majority of them, and knowing what works in one state and being able to translate that for other states." Health plans involved in BCAP appreciated the "hard-to-find forum that speaks to the particular challenges and issues of the Medicaid population."

By 2003, at least 75 percent of the states had participated in a Purchasing Institute, received a grant, or been the recipient of technical assistance. It was common for states to participate more than once and in multiple activities. Although health plans were a newer audience for the MMCP, about 42 percent of Medicaid managed care plans reported participating in one or more of the activities targeting them—BCAP work groups, one-time workshops or periodic quality summits, grants, and technical support activities. States and health plans overwhelmingly rated the activities in which they participated as excellent or good. In addition, awareness was high among other groups surveyed. However, this awareness was not necessarily deep; groups tended to be most aware of the activities targeted to them rather than of the full range of MMCP activities. Furthermore, health plans in which Medicaid made up a small share of total enrollment were less aware and less likely to participate in MMCP activities.

Outcomes Reflected in Changed Practices Among Core Audiences

Reputation is important, but a program's ultimate effectiveness must be judged by its outcomes. In this case, did the program make a difference in the way care is delivered under Medicaid managed care? For a complex and evolving program like the MMCP, this question is difficult to answer. To address it in this evaluation, Mathematica studied the experiences of the groups that most closely worked with the MMCP and examined overall trends.

States

The assessment of outcomes for the states built upon interviews with each Medicaid director in states with Medicaid managed care (forty-three of the forty-nine responded). Each responded to a set of questions about the MMCP's effect on the way they purchase Medicaid managed care. Half of those interviewed said they had made concrete improvements in their Medicaid managed care programs as a result of participating in MMCP, indicating that they saw the MMCP as fostering change and

improvements in their programs. To get a better idea of the MMCP's impact, the evaluation then examined examples of changes reported by the states. Although some changes reported by directors involved hard-to-assess intangibles, such as providing ideas for new initiatives and validating state perceptions and strategies, we found evidence that at least ten states had made concrete, substantive improvements in their Medicaid managed care programs as a result of activities of, and interaction with, the MMCP (all but one remained in place as of fall 2004). Examples include the development and public reporting of health plan performance information, changes to the way states oversee quality in Medicaid managed care, and new ways of contracting and working with plans (see the box, Examples of MMCP's Work with States).

Examples of MMCP's Work with States

Maryland. Maryland worked to revamp what it viewed as an overregulated Medicaid managed care program. Drawing on its participation in multiple Purchasing Institutes and on-site technical assistance, the state evolved a “value-based purchasing strategy” and tools to support it. The intent of the strategy was to identify performance goals that could be monitored and a series of rewards that plans would get from meeting those goals. Maryland used administrative and survey data and dialogue with plans to develop eight performance measures and compliance indicators. It also developed a set of related incentive payments to reward providers who met standards. (The payments unfortunately could not be made, because the funds that had been reserved for them were taken out of Medicaid's budget.) With MMCP funds, Maryland tackled the issue of how to set rates by using risk-adjusted data by profiling plan performance. The state also developed a consumer report card to give visibility to high-quality plans.

Indiana. A new Medicaid director pushed her state—which she regarded as behind the field—to adopt some of the techniques that other states were using to purchase care under Medicaid. Through participation in a Purchasing Institute and on-site technical assistance, Indiana developed a managed care report card highlighting areas such as member satisfaction, quality of care, and access. Reactions were positive, and the report card is now being used annually. The Medicaid program also worked with local public health officials to bring a grassroots disease management program, which specifically targets those with diabetes, chronic heart failure, asthma, and hypertension, as well as those “at high risk of chronic disease,” into the state's managed care program. Medicaid will fund chronic disease management as an extra benefit.

Michigan. The leadership of Michigan's Medicaid managed care program was concerned about the health plan choices available to beneficiaries and what the state paid to support these choices. Working with the MMCP, the Medicaid program incorporated quality-related and fiscal-solvency provisions into the bidding process. The changes led to a reduction in overall choice of health plans but an increase in the number of counties with more than one choice of plan. The changes also modified the way health plans were paid, and in so doing enhanced political support for the program.

As a complement to the Mathematica evaluation, the Robert Wood Johnson Foundation funded a separate study that included three state surveys to look for trends in their quality-monitoring activities.¹²

These data provide strong evidence that states had substantially increased “value-based purchasing”—that is, looking for value while taking into account cost and quality—from 1995 to 2001. Generally speaking, states moved from viewing their role as primarily that of a bill payer to one involving more aggressive purchasing practices that sought value. Over this period, states were increasingly likely to collect data on enrollee satisfaction and access to and quality of health plans, make such data available to plans (and, to a lesser extent, enrollees), and develop targeted quality-improvement programs linked to these measures. Progress was uneven. For example, more progress was made in measuring satisfaction than in measuring quality. Within quality measurements more was done on childhood immunizations than on other areas; mental health and substance abuse were substantially less developed. While the MMCP cannot necessarily be credited with causing these changes, it is encouraging that the trend data show improvement in those areas in which the MMCP has been active.

Health Plans

The health plans surveyed also reported that MMCP participation led them to make changes in the way they deliver care. To confirm such reports, the evaluators conducted in-depth interviews with representatives of health plans that participated in four of the first five BCAP work groups. The majority of those interviewed said that the health plan had made changes as a result of the plan’s participating in BCAP, with most of those changes still in place three to twelve months later and some plans continuing to generate change after the end of the BCAP. (See box, Examples of Changes in Care Delivery via BCAP.) Most participants said that BCAP had changed the way they think about quality improvement and had led them to approach the issue of quality differently in other clinical areas, not just in the BCAP’s particular area of focus.

Examples of Changes in Care Delivery via BCAP*

Birth outcomes. One plan established an information hotline for pregnant women, gave them rewards if they reported pregnancies or completed postpartum visits, and developed a clinical outreach program to help follow up with members. In the first year of the program, identified pregnancies doubled and visit compliance increased 10 percent. The plan has now expanded the use of incentives to mammography and dental care. Another plan screens prenatal data, uses a risk assessment tool to conduct outreach, and has adopted new protocols to coordinate information and case management across the plan. The share of members with a completed risk assessment increased by 41 percent in the first five months.

Preventive care for children. One plan focused on improving early and periodic screening, diagnosis, and treatment, or EPSDT, rates for adolescents by providing incentives to both adolescent members and staff members at pilot community health centers. The plan increased the number of scheduled visits, and the EPSDT rate for adolescents at the sites increased by 12 percent over the first year of the pilot. The plan has since expanded the initiative statewide and has increased its overall EPSDT rate from 30 percent to 41 percent. Another plan increased its immunization rate for two-year-olds from 43 percent in 2000 to more than 60 percent in 2003 by educating providers about the importance of a reminder system and helping them adopt or improve their systems.

* Plan names are not used because the information was gathered on the promise of confidentiality.

Asthma. One health plan developed an electronic asthma registry and uses it to sort children aged two to eighteen with asthma by their level of illness or risk. It uses an assessment survey to identify “out of control” asthmatics so that an action plan can be developed. The plan developed action plans for 63 percent of identified members before staff turnover stalled further progress. Another health plan developed a registry from multiple data sources, including data on health care claims over time. After identifying high-risk members, the plan offered providers a bonus for making changes to improve care management. Over twelve months, the physicians increased preventive asthma medication prescriptions by 6 percent, and emergency room use by asthmatics declined.

Adults with chronic illness. One health plan targeted disabled beneficiaries with congestive heart failure or diabetes and other comorbidities who resided in rural areas. Using a system of case management by telephone, the plan demonstrated a decline in hospitalization rates, length of stay, and total monthly costs per member that resulted in an overall 47 percent reduction in costs. The plan has since extended the telephonic case management intervention to other areas of the state. Another plan specializing in care for the disabled found that 70 percent of its members were at risk for three preventable conditions associated with immobility—pneumonia, urinary tract infection, and mechanical bowel obstruction. The plan taught members at risk for these conditions to notice and respond rapidly to symptoms and also educated primary care physicians on the same topic. The plan believed that the interventions improved care for two of the three preventable conditions, although developing adequate data on this point was difficult because of the small number of patients involved.

Whether the changes are having a positive effect is hard to know. Most health plans participating in BCAP struggled to track the outcomes of their interventions. Collecting process measures of change proved harder for some topics, such as chronic disease in adults and birth outcomes, than for others, such as asthma and preventive care for children, largely because the latter have a strong evidence base on which to structure interventions and accepted measures of performance. Health plans that made little progress under BCAP or terminated their efforts early tended to be ones that experienced turnover in leadership or staff, or both, or adverse financial circumstances. Organizational stability appears to be an important precondition to maintaining improvements in care. Thus, states seeking to improve Medicaid managed care will benefit by encouraging as much stability as possible in the plans that participate in Medicaid managed care.

Consumer Groups

To help consumers navigate and interact with Medicaid managed care, the MMCP made two rounds of grants ranging from \$25,000 to \$50,000. These grants funded activities such as developing materials and holding education sessions, arranging meetings to involve consumers in the policy process or teach them how to get involved, and creating peer support programs to facilitate access to health care services. Although grantees typically did what they had proposed to do, the grants tended to be too few, too small, too localized, and too short in duration to lead to sustainable or broad-based change. Despite the lack of success, consumer groups viewed this support as important and were disappointed that more grant funding was not forthcoming.

Overall Program Effectiveness

The evaluation concluded that although there was room for improvement, the Medicaid Managed Care Program was effective in working with two of its three core audiences (states and health plans) during the period examined—2000 to 2003; it had less success in helping consumers, the third of its three target audiences. The MMCP's integration of technical assistance with other support to state Medicaid agencies and Medicaid managed care plans appears to have led many staff members of these organizations to change their thinking about the way they purchase and provide Medicaid managed care. In a meaningful number of cases, they viewed the combination of technical assistance and grants as more effective than either one alone. This was truer for the states, which had more grant experience with the MMCP, than health plans. Moreover, the MMCP has allowed the Center for Health Care Strategies to mature and gain respect, generating support and capacity that can be tapped by the Robert Wood Johnson Foundation and other foundations to pursue related program goals.

There are areas where performance could be stronger. In a field where leadership turns over frequently, the MMCP has not been as aggressive as it might have been in working with newly appointed state officials. In addition, although measurement is a crucial component of quality improvement, health plans participating in BCAP still struggle to develop valid measures to judge performance. The MMCP's reach is also much stronger for Medicaid-dominant plans than for commercial plans in which Medicaid makes up only a small share of enrollment. The MMCP's focus on consumers, its third core audience, has also been limited. Although many consumer groups are aware of the MMCP, the program has invested relatively little in initiatives to strengthen them.

Insights on Broader Issues

Beyond these findings, the MMCP evaluation sheds light on a number of issues facing philanthropies that pursue social change. These issues include the challenges in creating sustainable and meaningful change; whether support for change should target high, average, or low performers; and who should and will support efforts needed to build the infrastructure that an emphasis on prudent purchasing and quality improvement requires.

Creating Sustainable Change

A key question is how to support efforts that lead to valuable and sustainable change rather than those that leave little mark. Exploring the factors within the MMCP that facilitated or impeded meaningful change can provide some guidance in answering this question.

The MMCP experience suggests that its operational and hands-on support was helpful to states and health plans. Furthermore, the program's group-based support—through Purchasing Institutes and workshops that generated interaction among states and plans—leveraged resources and was viewed by participants as important. There also seems to be a relationship between the intensity of MMCP assistance received and successful change.

The MMCP evaluation also indicates that the commitment of top leaders within the organizations is important. Turnover in leadership can undercut progress, but sustainability can be achieved if change

can be institutionalized within a program. Under the MMCP, it often took a new director or a crisis to generate interest and the support needed to change the way Medicaid managed care was purchased. As many as one-quarter of all state Medicaid directors can turn over in a year, as they did between 2003 and 2004. If a change becomes part of the institution before new staff members arrive, the new people might simply accept the change as a normal part of the program.

Rapid turnover of state health officials, however, makes it hard to maintain the commitments needed to sustain change. In health plans, turnover may be an even more important barrier. In plans, quality could sometimes be improved “under the radar screen” by a dedicated medical director, but unless it had the support of the health plan’s leadership, it often died when the medical director left. Stability—both in the overall state program in which health plans operate and in the fiscal and organizational context of their own organization—is also important to the ability of health plans to introduce change.

Constraints of the Macro-Environment

The most fundamental threat to the success of programs like the MMCP is the eroded economy in many states and in the nation—a factor cited by all stakeholders as the primary constraint in all their efforts to improve Medicaid managed care. With fiscal stringency, managed care appears unlikely to disappear. Indeed, many state government officials look to the MMCP to help them become more efficient in negotiating the difficult economic environment. Tight resources, however, make it more challenging to keep plans and providers affiliated with the program, and change is hard to introduce if programs are unstable.¹³ Fiscal stringency also puts a premium on cost-saving innovation. Though tight budgets generate interest in more prudent purchasing of Medicaid managed care, they also can generate unrealistic expectations about what kind of cost savings Medicaid managed care can deliver and how fast.

Medicaid’s complex layers of eligibility reflect the use of the program by policy-makers to provide a safety net and address coverage concerns and multiple unmet health care needs in our country.¹⁴ Increased enrollment, including coverage of some people with very expensive needs, adds to Medicaid’s costs and strains the Medicaid budget. To the extent that the federal government and state governments reduce funding for Medicaid managed care, it will be harder for states to maintain the participation of health plans and providers and improve quality of care.

Targeting an Audience: Working with Leaders Versus Followers

Programs like the MMCP typically face tensions in defining their target audience. Working with “stars” can increase the probability of success and can serve to lead the field, but these high-performers might have succeeded on their own. Focusing on them may leave the rest of the field behind. The MMCP staff may like to target leading states capable of cutting-edge strategies that can then influence other states. But in fact the states that the MMCP works with are quite varied in the sophistication of their Medicaid managed care purchasing. Although participation was highest for the most sophisticated states (as judged independently by experts and surveys of state purchasing practices), participation levels were high among all but the least sophisticated states. Furthermore,

states with both high-level and moderate-level sophistication made concrete changes as a result of the program. Indeed, by some measures, moderately sophisticated states showed as much success as the most sophisticated ones, sometimes more.

Building Infrastructure: Whose Job Is It?

Changing purchasing practices and the way care is delivered requires substantial investment. It takes time and money to build the understanding, skills, and technical infrastructure to buy care well and to deliver a quality product. Foundations often are called upon to weigh the value of investing in infrastructure development, whose benefits are long-term and sometimes difficult to quantify, against investing in short-term projects whose value can be assessed more rapidly and in more tangible ways. Many foundations are reluctant to fund the former. The MMCP experience indicates, however, that outside support that complements internal organizational resources is valuable as a way of encouraging change, conveying technical insights, and developing the infrastructure essential to high-quality Medicaid managed care programs.

One can make the case that the ultimate responsibility for funding the kind of support provided by the MMCP lies with the entities responsible for the Medicaid program: the federal and state governments. But federal policy increasingly positions Medicaid as a state responsibility, and as a result technical assistance by federal agencies has diminished. Both state governments and health plans face substantial barriers in generating funds and resources for the kind of quick-turnaround support and training that the MMCP provides.¹⁵ In any case, a centralized focus is likely to be important in helping states and plans learn from one another. In this context, stakeholders may look to philanthropy to fill gaps.

The Bottom Line

In 1975, Howard H. Hiatt M.D., then dean of the Harvard School of Public Health, wrote an influential article on “Protecting the Medical Commons: Who Is Responsible?”¹⁶ He likened the challenges in health care to those of shepherds sharing a field. With limited resources (a single field), there are trade-offs between the individual and collective good. Although Hiatt’s focus was on medical technology and the decisions physicians make about who gets what, the tensions he described parallel those inherent in building an infrastructure for quality improvement. Though all seek its benefits, the incentives of the current structure do not yield the investments needed to generate them. This is a problem if policy-makers are serious about the importance of leveraging purchasing to pursue better-quality care.

It is one thing to set a goal for improving Medicaid managed care. It is quite another to accomplish that goal when Medicaid exists in an environment of limited funds and support. The MMCP highlights the contribution that day-to-day work by states and health plans can make in improving care under Medicaid managed care. But on-the-ground efforts can be successful and maintained only to the extent that Medicaid itself is able to generate adequate and continuing support for quality improvement and for the program itself.

Appendix: Examples of Early MMCP Grantmaking, 1996–1998	Model Demonstration Grants	Award Date
	A Strategy to Provide Medicaid Managed Care Services to the Disabled (Commonwealth of Massachusetts)	June 1996
	Study of Mental Health Crisis Intervention Services for Dually Eligible Elderly (Mt. Hood Community Mental Health Center, Oregon)	October 1996
	Innovative Efforts to Integrate and Restructure Managed Care to the Medically Indigent (University Health System, Texas)	January 1997
	Development of an Integrated System of Health and Support Services for SSI Beneficiaries (Clark County, Washington)	January 1997
	Integration of Services for Children with Mental Health Needs (Greater Kansas City Community Foundation, Missouri)	August 1997
	Development of Criteria for Medicaid Managed Care Special Needs Plan (County of Chemung, New York)	October 1997
	A System of Managed Care for Persons with Serious Mental Illness and Substance Abuse (State of Wisconsin)	February 1998
	Medicaid Managed Care for Special Needs Populations (State of Utah) Healthier Babies Project (Health Partners, Pennsylvania)	April 1998 April 1998
	Development and Implementation of AIDS Centers of Excellence (Tennessee Opportunity Programs Inc, Tennessee)	July 1998
	The Safety Net Project (State of Colorado)	September 1998
	Implementation of Statewide Managed Long-Term Care in Delaware (State of Delaware)	December 1998
	Best Practice Grants	Award Date
	Consumer Participation in Developing and Monitoring Medicaid Managed Care (National Health Law Program, North Carolina)	January 1996
	Rate Setting for High-Risk Populations (Regents of the University of California for work with 11 states)	March 1996
	Member Satisfaction Survey with Acute Care AHCCCS Medicaid Managed Care (Arizona Health Care Cost Containment System)	March 1996
	Data Requirements in Medicaid Managed Care (The MEDSTAT Group, Illinois)	July 1996
	Conference on Current Approaches for Medicaid Client Education (Center for Health Policy Development, Maine)	August 1996
	A Health Status Based Method for Risk-Adjusted SSI Premiums (University of Washington, Washington)	August 1996
	Conference on Alternative Managed Long-Term Care Models for CA (The MEDSTAT Group, California)	April 1998
	Case Management in Medicaid Managed Care for People with Developmental Disabilities (Developmental Disabilities Health Alliance)	July 1998

Notes

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3. Kaiser Family Foundation. State Health Facts On-Line, Selected Tables on Medicaid Managed Care and Trends. (www.state-healthfacts.org), accessed Oct. 25, 2004.
4. Schneider, E. C., Landon, B. E., Tobias, C., and Epstein, A. M. "Quality Oversight in Medicaid Primary Care Case Management Programs." *Health Affairs*, Nov.–Dec. 2004, 23(6), 235–242.
5. Draper, D. A., Hurley, R. E., and Short, A. C. "Medicaid Managed Care: The Last Bastion of the HMO?" *Health Affairs*, 2004, 23(2), 155–167.
6. See, for example, Gold, M., Mittler, J., Draper, D., and Rosseau, D. "Participation of Plans and Providers in Medicaid and SCHIP Managed Care." *Health Affairs*, Jan.–Feb. 2003, 22(1), 77–88; Zuckerman, S., McFeeters, J., Cunningham, P., and Nichols, L. "Changes in Medicaid Physician Fees, 1998–2003: Implications for Physician Participation." *Health Affairs*, June 23, 2004, W4–374; and Bindman, A., Yoon, J., and Grumbach, K. "Trends in Physician Participation in Medicaid: The California Experience." *Journal of Ambulatory Care Management*, 2003, 26(4), 334–343.
7. Vladeck, B. "Where the Action Really Is: Medicaid and the Disabled." *Health Affairs*, Jan.–Feb. 2003, 22(1), 62–76; Frank, R. G., Goldman, H. H., and Hogan, M. "Medicaid and Mental Health: Be Careful What You Ask For." *Health Affairs*, Jan.–Feb. 2003, 22(1), 101–113; and Crowley, J. S., and Elias, R. *Medicaid's Role for People with Disabilities*. Washington D.C.: Kaiser Family Foundation, Aug. 2003.
8. For additional information describing the program, see White, J. S., and Gold, M. *The Medicaid Managed Care Program of the Center for Health Care Strategies*. Washington, D.C.: Mathematica Policy Research, Dec. 2004. (Available from the Robert Wood Johnson Foundation.)
9. The maximum funding level was increased to \$750,000 in 2002, but grants of this size are rare.
10. Felt-Lisk, S. "Monitoring Quality in Medicaid Managed Care: Accomplishments and Challenges at Year 2000." *Journal of Urban Health: Bulletin of New York Academy of Medicine*, Dec. 2000, 77(4), 536–559.
11. Berwick, D. M. "Developing and Testing Changes in Healthcare Delivery." *Annals of Internal Medicine*, Apr. 15, 1998, 128(8), 651–665; Kilo, C. M. "A Framework for Collaborative Improvement: Lessons from the Institute for Healthcare Improvement's Breakthrough Series." *Quality Management in Health Care*, 1998, 6(4), 1–13.
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13. Gold, Mittler, Draper, and Rosseau (2003).
14. Rowland, D., and Tallon, J. R. "Medicaid: Lessons from a Decade." *Health Affairs*, Jan.–Feb. 2003, 22(1), 138–144; and Holahan, J., and Ghosh, A. "Understanding the Recent Growth in Medicaid Spending, 2000–2003." *Health Affairs*, Jan. 2005, W5–52.
15. White and Gold (2004); and Martin, R., and Kenneson, M. "A Focused Survey of the Medicare and Medicare Payor Markets for Convening and Programmatic Technical Assistance." Submitted to the Robert Wood Johnson Foundation by Mathematica Policy Research on August 25, 2004. The latter identified a number of barriers to state support for such activities. These barriers include difficulties in securing relatively small dollar amounts for staff training and educational activities, budget and administrative constraints on staff travel, and lack of capacity for developing effective proposals to secure outside foundation funds, which limit interest in seeking support for small amounts of money that do not justify the effort. Martin and Kenneson also found that federal funding for Medicaid technical assistance has diminished over time, since federal policy regards this form of support as a state responsibility. Though health plans may have more administrative flexibility, they tend to rely on monthly capitation financing streams that are both tight and poorly suited to generating large amounts of capital for investments.
16. *New England Journal of Medicine*, 1975, 293, 135–140.