Robert Wood Johnson Foundation

Published: August 9, 2013
Program Results Report
Grant ID# MAM

Medicaid Managed Care Program

Helping states and managed care health plans improve the care provided to beneficiaries of Medicaid and the State Children's Health Insurance Program

SUMMARY

The Medicaid Managed Care Program *helped states and managed care health plans improve the care provided to beneficiaries of Medicaid and the State Children's Health Insurance Program.*[1] *The Robert Wood Johnson Foundation (RWJF) established the Center for Health Care Strategies (CHCS) in 1995 to direct the program.*

The program started with a broad focus on funding research and demonstration projects. In 1999, it launched an intensive series of technical assistance and training for state Medicaid agencies and managed care plans. Purchasing Institutes helped states become better purchasers of health care, and Best Clinical and Administrative Practices Workgroups helped managed care plans improve their clinical and administrative practices. Mathematica Policy Research evaluated this phase. See Assessing the New Strategy and Evaluating the Program (pages 16–17).

Both efforts began with a focus on the entire Medicaid population, but starting in about 2004, the program began to emphasize improved care delivery for individuals with complex health problems; reducing disparities in care; and providing expertise to RWJF staff and programs, such as Aligning Forces for Quality, *and to the federal government.*

During this time, the program's efforts also evolved from a single stakeholder focus to involving states, health plans, and providers to improve

[1] Signed into law in 1997, the State Children's Health Insurance Program (S-CHIP or CHIP) provides health coverage to children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. Like Medicaid, CHIP is managed by the states and funded jointly by the states and the federal government.

care delivery across a region. RWJF funding ended in 2012, but the center has sustained and expanded its work through a variety of public and private funding sources totaling more than $57 million since 2000.

CONTEXT

Medicaid, the main source of access to health care for low-income and disabled people, covered 40.2 million people and cost about $150 billion in 1994.[2] Each state designs and manages its own Medicaid program, which the state and the federal government jointly finance. By 1995, the federal government's requirement that states help fund certain services and rising Medicaid expenses had caused severe budget problems in many states.

Initially, states began using managed care in their Medicaid programs primarily to control health care costs. Officials believed that capitated health plans[3] would reduce reliance on expensive care provided in emergency rooms, and that the plans would provide beneficiaries with a regular source of primary care for a set monthly fee.

Some states had made enrollment in managed care mandatory for some beneficiaries. Between 1990 and 1995, the percentage of Medicaid beneficiaries enrolled in managed care increased from 9 to 29 percent nationwide,[4] and states were starting to use managed care more aggressively.

States Look to Managed Care for Better Access and Quality

State policy-makers also hoped that managed care would enable them to improve access to care and the quality of that care. Often, there were not enough doctors in areas where Medicaid beneficiaries lived, and many doctors would not participate in the program due to Medicaid's low reimbursement.

"A Medicaid fee-for-service card was essentially a hunting license. You'd get a card and see if you could hunt down a provider who would take Medicaid," said Stephen A. Somers, PhD, an associate vice president and program officer at RWJF at the time. Somers left the Foundation in 1995 to establish the Center for Health Care Strategies (CHCS) and manage the *Medicaid Managed Care Program*. He is the center's president and chief executive officer.

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[2] According to the Health Care Financing Administration, the federal agency that is now the Center for Medicare & Medicaid Services

[3] For a monthly payment per person enrolled in the managed care plan (the "capitation rate"), the plan took responsibility for providing or arranging medical care covered under the state's Medicaid program.

[4] According to the Kaiser Family Foundation's "State Health Facts Online, Selected Tables on Medicaid Managed Care and Trends," 1995.

Due to poor access to care, Medicaid beneficiaries often waited until their health problems escalated and then went to emergency rooms and hospital outpatient departments instead of doctors' offices. Without a consistent health care provider to coordinate care, Medicaid beneficiaries tended to get lower-quality, higher-cost services. Policy-makers were especially worried about people with complex conditions—chronic illnesses, mental health problems, and substance abuse—who needed services from multiple providers. The theory was that managed care, with its network of providers, could lower costs and provide better access to care for Medicaid beneficiaries. It also had the capacity to monitor providers and spur improvements in the quality of care.

Managed Care Transforms Medicaid

But managed care was changing the nature of Medicaid and it required state Medicaid agencies to transform the way they worked. In fee-for-service Medicaid, the agencies focused primarily on processing claims and monitoring doctors and hospitals for overuse of services.

Turning to managed care meant that state Medicaid agencies had to become sophisticated group purchasers in a dynamic market and, where necessary, protect beneficiaries from managed care organizations with incentives to underserve. "This was a whole new approach to overseeing care for their beneficiaries," said Somers.

Most states were not thinking about Medicaid managed care strategically or geared up to be good contractors, says Robert Hurley, PhD, who was a professor of health administration at Virginia Commonwealth University when he joined the national advisory committee of the *Medicaid Managed Care Program*.[5] Hurley began studying Medicaid managed care in the mid-1980s. By 1995, he had published a book[6] and articles on Medicaid managed care and evaluated demonstration programs for the federal Center for Medicare & Medicaid Services (CMS).

"A lot of states adopted Medicaid managed care because they thought it might save money," he said. "They weren't necessarily thinking it would enhance the well-being of their Medicaid beneficiaries."

Working with Medicaid beneficiaries was new for managed care organizations, which may have been "indifferent to or skeptical of Medicaid managed care as a line of business," said Hurley. Staff at most managed care organizations lacked experience and familiarity with the Medicaid population: mostly low-income people with health and social problems—including mental health problems, substance abuse, inadequate transportation, poor housing, violence, and language and literacy challenges.

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[5] Hurley is now a professor emeritus at Virginia Commonwealth University.
[6] Hurley R, Freund D, and Paul J. *Managed Care in Medicaid: Lessons for Policy and Program Development.* Ann Arbor, MI: Health Administration Press, 1993.

In addition, advocates for low-income people and the safety-net providers serving Medicaid recipients opposed Medicaid managed care. Advocates thought managed care would lead to exploitation, and staff at the federally qualified health centers and hospitals who cared for people on Medicaid were worried that managed care networks would eliminate or underpay their institutions.

Meanwhile, states and managed care organizations were struggling to get managed care right for Medicaid beneficiaries.

RWJF's Interest in This Area

Assuring that Americans have access to health care is one of RWJF's long-standing goals. RWJF staff viewed managed care as an opportunity to both reduce the cost and improve the quality of health services delivered to low-income Americans covered under Medicaid. Staff also realized, however, that managed care could negatively impact the quality of health care provided to Medicaid beneficiaries if not done right.

"RWJF recognized that Medicaid was being transformed by this movement toward managed care and that there were significant issues arising in various states. There was concern about the capacity of the states and the health plans to do this without guidance," said Somers.

RWJF launched the *Medicaid Managed Care Program* in 1995 with the goal of improving access to and quality of care for Medicaid beneficiaries, particularly for those with chronic illness or disabilities. "This was an opportunity to transform the Medicaid program," said Nancy Barrand, MPA, senior adviser for program development at RWJF and the first program officer for the *Medicaid Managed Care Program*.

PROGRAM OVERVIEW

The *Medicaid Managed Care Program* helped states and health plans improve their use of managed care for Medicaid and CHIP beneficiaries from 1995 through 2012. The program used a structured but collaborative learning approach that focused on, first, bringing together groups of states and groups of health plans, and then, combining these groups with other groups in multi-stakeholder collaboratives. It also provided technical assistance and training to states and health plans, made grants, and supported research and analysis and other projects.

To a lesser extent, the program supported some work to help consumers navigate and establish a formal role in Medicaid and similar managed care systems through grants to consumer and family-focused organizations.

Funding

RWJF supported the *Medicaid Managed Care Program* with $57 million between 1995 and 2012 with the bulk of that funding then regranted to states, Medicaid health plans and providers, and external health policy analysts and researchers. The Foundation's Board of Trustees originally authorized the program in 1995 and reauthorized it in 1999 and in 2002.

Since 2000, CHCS has leveraged more than $57 million in additional investments from foundations, corporate philanthropy, and the federal government—all building on the *Medicaid Managed Care Program's* original goals. See Appendix 1 for a list of funders.

Management

Instead of choosing an existing organization to manage the *Medicaid Managed Care Program*, RWJF seeded the start-up of a separate nonprofit organization, the Center for Health Care Strategies, directed by its former program officer Somers. Within a new organization, the *Medicaid Managed Care Program* would be able to move faster than in a traditional national program office, more often than not housed at a university, according to Somers. This was important because Medicaid managed care was moving quickly and the program needed to be able to respond to policy issues and developments as they unfolded.

Based near Princeton in Hamilton, N.J., CHCS has become a nonprofit health policy resource center dedicated to improving health care access and quality. Staff members work with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve low-income Americans, especially those with complex and high-cost health care needs.

National Advisory Committee

A national advisory committee helped CHCS staff choose grantees and provided guidance on program design. The committee was comprised of experts in Medicaid, including people known to key audiences of the *Medicaid Managed Care Program* and researchers experienced in working with state staff. See Appendix 2 for a list of members.

Evaluation

RWJF contracted with Mathematica Policy Research in Princeton, N.J., to provide an early assessment of the *Medicaid Managed Care Program*[7] and then again to evaluate the program for the years 2000–2003.[8] Mathematica Policy Research collects and analyzes

[7] Grant ID# 40120: $139,021, September 1, 2000 to February 28, 2002.
[8] Grant ID#s 45772, 46351, and 50352: $991,031, August 1, 2002 to January 31, 2005.

information to assess the effectiveness of policies and programs to improve public well-being. Marsha Gold, ScD, led the evaluation team.

OVERALL PROGRAM ACTIVITIES, RESULTS, AND FINDINGS

The *Medicaid Managed Care Program* initially focused on grantmaking aimed at improving services for the general population of Medicaid beneficiaries, as well as those who were chronically ill or disabled. In 1999, the program's direction evolved to offer intensive technical assistance, and concentrate on three core audiences: state governments, health plans, and consumers.

Under this approach, the *Medicaid Managed Care Program* worked to establish a quality improvement culture in Medicaid managed care by bringing groups of states and groups of health plans together to learn from each other. The program also started making grants to consumer organizations.

In about 2004, the *Medicaid Managed Care Program* evolved further toward building multi-stakeholder alliances to advance quality and reduce disparities by bringing together groups that included states, health plans, and other stakeholders. The program also provided support to a variety of federal and RWJF programs and initiatives.

The Early Years: Quick-Strike Grantmaking

RWJF and CHCS designed the *Medicaid Managed Care Program* to move more quickly than a traditional national program and award "quick-strike" grants. Because the center could make grants on its own without going through the Foundation's usual process, it was able to respond to policy issues and make small grants "that would get answers to people in states and health plans and consumer groups more quickly," said Somers.

The program invested in:

- Design and development of pilot demonstration programs for specific subsets of people on Medicaid (for example, people with disabilities)
- Best practice grants to identify, develop, and test innovative practices to improve the delivery of Medicaid managed care
- Policy study grants to document best practices in management and operations of Medicaid managed care or provide analysis of market trends and policies that affect the implementation and outcomes of Medicaid managed care

From 1995 through 2002, the *Medicaid Managed Care Program* awarded 177 grants:

- **Fifty-five model demonstration project grants.** These grants of up to $500,000 supported state Medicaid agencies and health plans to develop new models to manage care for people with disabilities, chronic illness, and other complex care needs. The

program also gave initial planning grants of up to $100,000 to let grantee organizations explore the feasibility of their ideas or refine their plans before applying for a demonstration grant. An example of a demonstration grant follows:

— The Minnesota Department of Human Services set out to establish a large-scale mandatory managed health care program for people with disabilities from birth to age 64 under a Medicaid Managed Care Program demonstration grant. It was unable to do this due to complex and rigid authorizing legislation and financial and structural problems in implementation. With support from CHCS, the department applied the grant funds to continuing the development of Minnesota Disability Health Options, a managed health care program for people ages 18–64 with physical disabilities who are eligible for Medicaid and live in the Minneapolis-St. Paul area.

  Minnesota Disability Health Options integrates financing and delivery of Medicaid and Medicare services, offering acute, hospital, and behavioral health care; home care and home- and community-based services; 180 days of nursing facility care; and more. Medicaid fee-for-service pays for drugs. Enrollment is voluntary and people can return to Medicaid fee-for-service at any time. Participants reported high levels of satisfaction with their care.

- **Sixty-six best practices grants.** These grants of up to $100,000 supported state Medicaid agencies, health plans, consumer organizations, health services researchers, and policy analysts to identify, develop, and test innovative practices to improve the delivery of Medicaid managed care. Many of these grants advanced the field; others provided baby steps and incremental lessons to help inform future efforts.

  — Under a best practice grant, researchers at the University of California, San Diego, produced a manual on risk-adjusted rate setting (setting Medicaid payments for providers reflecting their patients' diagnoses and severity of illness).

- **Fifty-six policy study grants.** These grants of up to $100,000 supported state Medicaid agencies, health plans, consumer organizations, health services researchers, and policy analysts to (1) analyze market trends or federal, state, and health plan policies, or (2) provide guidance on documenting best practices in management and operations of Medicaid and SCHIP managed care.

  — Under a policy study grant, researchers at the George Washington University School of Public Health and Health Services conducted the first national, detailed examination of state Medicaid managed care contract documents, which provided critical guidance for states operating largely in isolation to learn from peer states and better understand how to use managed care contracting strategies effectively.

Problems with This Grantmaking Approach

Within a few years, both RWJF and CHCS concluded that grantmaking was not the most effective way to improve Medicaid managed care. It was too difficult to truly engage the

main forces—state Medicaid agencies and Medicaid managed care plans—through grants. And once the funding ended, often so did the work done under the grant.

The program received few strong proposals for the model demonstration grants. For example, the initial call for proposals in 1996 resulted in 26 applications, of which the program funded five projects.

Commonwealth Care Alliance

Commonwealth Care Alliance is a not-for-profit care delivery system committed to integrating health care and related social support services for low-income frail older adults and adults with disabilities in Massachusetts. The alliance has its roots in a model demonstration project grant from the *Medicaid Managed Care Program*.

In 1999, the *Medicaid Managed Care Program* gave a grant to the Neighborhood Health Plan, a health maintenance organization in Boston, to establish the Community Medical Alliance, a prepaid care delivery program to provide enhanced primary care and mental health services, addiction treatment, care coordination, and support services for people with complex health needs. In 2003, this care model became the Commonwealth Care Alliance.

In 2013, Program Director Somers reports that this not-for-profit, consumer-governed prepaid care system is lauded nationally for its innovative approach to integrating care for people with complex needs covered under Medicaid and for those eligible for both Medicaid and Medicare.

Under another RWJF program managed by the Center for Health Care Strategies, the *Medicaid Leadership Institute*, Massachusetts' Medicaid Director Julian Harris, MD, is working to expand Commonwealth Care Alliance's model within the state. Somers notes that "Harris and Massachusetts were among the first to win a MOU [memorandum of understanding] from the new federal Medicare-Medicaid Coordination Office. Read the Program Results Report about the *Medicaid Leadership Institute.*

"State Medicaid agencies and Medicaid managed care plans have a lot of money. If you have to pay them to get them to do something, that might not be a motivator that would make them all that interested in doing it," said Michael B. Rothman, MPP, the former RWJF program officer on the *Medicaid Managed Care Program*,[9] who helped move the program away from grantmaking toward a strategy of technical assistance and training.

Grants alone could not overcome the key obstacles to improving Medicaid managed care—a commitment to doing so and the ability to execute improvements effectively.

[9] Rothman is now director of Quality and Operations Support at the Permanente Medical Group in Oakland, Calif.

Over the next few years, CHCS staff began to focus more on providing intensive technical assistance to states and health plans.

Medicaid Managed Care Advances More Slowly Than Expected

At the same time, Medicaid managed care overall was advancing less rapidly than envisioned, and most states were comfortable just targeting families and children. The *Medicaid Managed Care Program's* early work had helped reveal the extent of the challenges of enrolling beneficiaries who are chronically ill or disabled in Medicaid managed care: advocates and safety-net providers who were strongly opposed to Medicaid managed care, health plans that were indifferent or skeptical, and states that were not willing to force more use of Medicaid managed care.

A Shift in Direction: Establishing a Medicaid Managed Care Quality Improvement Culture

Under RWJF's 1999 reauthorization, the *Medicaid Managed Care Program* became "a driver of improvement" instead of "a passive grantmaker and an approver of ideas," says Rothman. The *Medicaid Managed Care Program* defined three core audiences for its work—state agencies, health plans, and consumers—and added in-depth technical assistance and training. The technical assistance and training focused on both general population issues in Medicaid as well as considerations for designing programs for individuals with chronic illnesses and disabilities.

"We moved to a more highly leveraged model that required some interest and engagement and leadership from the Medicaid agency, health plan, or consumer organization, so they were bringing something to the table," said Rothman. "They worked with the center on an improvement project because they wanted to, not because we were paying them."

The *Medicaid Managed Care Program* began to build a collaborative performance improvement approach to help the state Medicaid agencies and Medicaid managed care plans learn from each other and translate policy into actionable opportunities, with a focus on:

- Technical assistance and training
- Purchasing Institutes to help states learn how to purchase high-quality, cost-effective managed care services[10]

[10] Before the Center for Health Care Strategies developed its purchasing institute, RWJF funded the Alpha Center in Washington (now called AcademyHealth) to develop a purchasing institute that would train public-sector health care purchasers in value-based purchasing—the term for using purchasing power to improve the quality of health care. The health policy consultant who conceived the idea of a purchasing institute, Lynn M. Etheredge, was interested principally in improving Medicare purchasing but anticipated

- Best Clinical and Administrative Practices Workgroups for health plans to support quality improvements in clinical and administrative practices in managed care plans

The *Medicaid Managed Care Program* did continue to give model demonstration and best practices grants, but made far fewer of these grants. To help consumers navigate and establish a formal role in Medicaid and similar managed care systems, the program also offered grants to consumer groups.

Technical Assistance and Training

The collaborative performance improvement strategy gave state Medicaid agencies and Medicaid managed care plans opportunities for:

- Peer-to-peer learning
- Exposure to policy and operational experts
- Development of a Medicaid-focused continuous quality improvement approach
- Structured collaboration within organizations and with external groups
- Facilitated discussions with key contacts at CMS, as relevant

CHCS also provided participating state Medicaid agencies and Medicaid managed care plans with one-on-one technical assistance (via telephone and site visits) and group technical assistance (via group telephone calls), mostly in relation to the other two program components: Purchasing Institutes and Best Clinical and Administrative Practices Workgroups. Staff provided some technical assistance to the consumer groups that received grants, especially in helping them develop communications materials.

CHCS also sponsored national workshops and summits on quality for wide dissemination of emerging innovations among states and health plans.

The focus on performance improvement in Medicaid managed care and on providing assistance to help states and managed care plans build their capacity to serve Medicaid beneficiaries also enabled CHCS to attract other funders to sustain its work after the RWJF funding for the *Medicaid Managed Care Program* ended.

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the initiative would also benefit other public sector health programs, including Medicaid and local and state programs responsible for purchasing health care for public employees. During the planning process for the *National Health Care Purchasing Institute*, the planning team decided to expand the target audience to include large corporations and other private sector purchasers as well. In part because of this shift in focus, RWJF decided to fund the creation of separate purchasing institutes at the Center for Health Care Strategies to address the special needs of state Medicaid agencies.

Purchasing Institutes

The *Medicaid Managed Care Program* coordinated 15 Purchasing Institutes,[11] designed "of, for and by" staff in state Medicaid agencies to help them improve their skills in buying Medicaid managed care health services. Since the first Purchasing Institute in 2000, more than 47 states have participated.

The teams, comprised of senior staff from different states selected competitively based on their applications, participated in each institute, working on programmatic and operational improvements. Each Purchasing Institute focused on a specific issue (such as monitoring health plan quality or managed care for people with disabilities) and included a mix of face-to-face sessions through a two- or three-day workshop as well as conference calls and webinars over a 12- to 18-month period.

Example of a Purchasing Institute

The Return on Investment Purchasing Institute (2007 to 2008) focused on building state capacity to forecast the financial returns that investments in quality improvement could generate. Eight states[12] evaluated the return on investment potential of specific quality initiatives and analyzed the implications of return on investment analyses for program planning and resource allocation. They received focused training and intensive technical assistance from CHCS for these activities.

The teams used an early prototype of the CHCS Return on Investment Forecasting Calculator, a Web-based tool for evaluating the net financial benefits of initiatives designed to improve health care quality and reduce costs. Based on their experiences, the tool was refined and later made available publicly via the CHCS website. A user's guide is also available online.

[11] With other funding, the Center for Health Care Strategies coordinated five additional Purchasing Institutes.

[12] Arizona, Colorado, Connecticut, Idaho, Louisiana, Oklahoma, Pennsylvania, and Washington.

Managed Care for People with Disabilities Purchasing Institute: How It Helped Medicaid Managed Care in California

The Managed Care for People with Disabilities Purchasing Institute ran from 2006 to 2008 and helped teams from California, Indiana, Nevada, New York, Pennsylvania, and Washington enhance the capacity of their Medicaid managed care programs to purchase care for and serve people who are eligible for the federal Supplemental Security Income program.[1]

The teams designed, implemented, or expanded enrollment of their Medicaid managed care programs to include these beneficiaries. They received focused training and intensive technical assistance on topics such as the development of new performance measures for people with disabilities.

Participating in this purchasing institute informed California's roll-out of Medicaid managed care for seniors and people with disabilities in 2011. "There wasn't a lot of information about the experience of Medicaid plans in California with managed care," said Chris Perrone, MPP, deputy director of the California HealthCare Foundation's Health Reform and Public Programs Initiative.

Through the Purchasing Institute, a commissioned report on best practices in contracting for Medicaid managed care; a conference about Medicaid managed care; and other projects, the center gave Medicaid managed care stakeholders in California "essential information they needed to make better decisions" and made the state's Medicaid managed care program better than it otherwise would have been," says Perrone. The participation of California's Medicaid director in the RWJF-funded *Medicaid Leadership Institute* also contributed to the skillful expansion of Medicaid managed care. See Progress Report for more information on the *Medicaid Leadership Institute*.

The Center for Health Care Strategies developed many resources (tools, briefs, and reports) based on the Managed Care for People with Disabilities Purchasing Institute and disseminated them to all 50 states.

[1] The Supplemental Security Income program pays benefits to disabled adults and children who have limited income and resources.

Read more about this Purchasing Institute and related resources.

Best Clinical and Administrative Practices Workgroups

The 11 Best Clinical and Administrative Practices Workgroups focused on improving the quality and cost-effectiveness of Medicaid managed care.[13] Like the Purchasing Institutes, the workgroups were "of, by, and for" the participants, primarily staff from health plans serving Medicaid beneficiaries, along with representatives of state primary care case management programs and other stakeholders. Participants had to apply and be selected. Between 2000 and 2008, staff from more than 150 managed care plans in 37 states participated.

The Best Clinical and Administrative Practices Workgroups. modeled after the Breakthrough Series Collaboratives of the Institute for Healthcare Improvement, allowed providers to benefit from collaborative learning.[14] They gave Medicaid health plans a way to design and test continuous quality improvement approaches and a simple, consistent structure for creating and instituting operational change in their quality improvement processes.

These workgroups focused on high-priority areas, including high-risk pregnancy, pediatric asthma, children with special needs, and people with disabilities. For each area, CHCS convened at least one workgroup of up to 15 health plans. Each workgroup met three or four times over nine to 12 months. Of note, both the Commonwealth Fund and the Annie E. Casey Foundation, among other funders, invested in Best Clinical and Administrative Practices Workgroups based on the success of the initial efforts supported under the *Medicaid Managed Care Program*.

See the Program Results Report for a description of how one workgroup developed strategies to reduce racial and ethnic disparities in health care.

Results of Some of the Workgroups

Outcomes of participating in workgroups included:

- **Achieving Better Care for Asthma Best Clinical and Administrative Practices Workgroup:** Health Plus in New York increased the ratio of control medications to percent and emergency department visits by 9 percent, rescue medications (which provide quick relief during an asthma flare-up) by 38 percent, and reduced asthma-related inpatient visits by 11 percent.

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[13] The Center for Health Care Strategies coordinated eight additional workgroups with other funding.

[14] These short-term collaboratives bring together teams from many hospitals or clinics to seek improvement in a focused topic area while reducing costs. The idea is to bridge the gap between what is known—the sound science that can be used to improve the costs and outcomes of current health care practices—and what providers do. The collaboratives create a structure in which organizations can easily learn from each other and from recognized experts. RWJF's program *Improving Chronic Illness Care* also used this collaborative model. See the Program Results Report.

- **Toward Improving Birth Outcomes Best Clinical and Administrative Practices Workgroup:** Sentara Healthcare in Virginia avoided 1,600 neonatal intensive care unit days and potentially $2.3 million in neonatal intensive care unit costs through a new prenatal case management program.

Identifying and Piloting Managed Care Best Practices for Asthma Care

Asthma is the most common reason for hospitalization among low-income children and adults. Although nationally recognized guidelines on treating and preventing asthma are available, it is difficult for health plans to implement them effectively. Families of people with asthma may have additional problems, and often put a low priority on asthma treatment.

During the Achieving Better Care for Asthma Best Clinical and Administrative Practices Workgroup, 11 health plans developed many strategies to identify children with asthma, stratify them by asthma severity, and improve care management for those with the highest risk. The Center for Health Care Strategies compiled the lessons learned from this workgroup in a toolkit that offers a practical approach for health plans to identify enrollees with asthma and improve asthma care delivery.

- **Improving Preventive Care Services for Children Best Clinical and Administrative Practices Workgroup:** Community Health Network in Connecticut raised early and periodic screening, diagnostic and treatment (EPSDT) rates from 69 to 94 percent through a provider office-based intervention.

Read more about the Best Clinical and Administrative Practice Workgroups.

Managed Care Pricing Forum

From 1999 to 2002, CHCS also sponsored the Managed Care Pricing Forum series. Each forum brought together state Medicaid agencies and health plans to discuss emerging issues, identify areas that needed analysis, and provide feedback on reports, proposals, and policy initiatives. The center gained considerable insight into the capacities and needs of the states and health plans in purchasing and quality improvement through the forum.

For example, a forum on the Balanced Budget Act (BBA) of 1997 and the proposed BBA regulations on Medicaid managed care commissioned a study to estimate the impact of key provisions of the proposed regulation. The subsequent report, *Impact of the Proposed Medicaid BBA Regulation on Medicaid Managed Care* (2000),[15] raised awareness among

[15] Available upon request to webmaster@chcs.org, or by calling 609-528-8400.

key stakeholders and was cited in the final regulation (January 2001) as "the best information we currently have available on the potential incremental impact of the proposed regulation."

In 2002, the Managed Care Pricing Forum began to focus more broadly on pharmacy purchasing. From 2002 to 2005, this forum convened a small group of federal, state, and local purchasers, health plan CEOs, consumer representatives, pharmaceutical manufacturers, and health care experts to identify solutions to the exponential growth in the cost of pharmacy services.

Consumer Action Agenda

Staff from RWJF and CHCS knew from the onset that consumers would be a tougher audience to engage than state Medicaid agencies and Medicaid managed care health plans. "Most Medicaid beneficiaries do not participate in any kind of consumer organization. There's no AARP for Medicaid," said Somers.

The center's strategy focused on funding consumer groups to produce materials to help consumers select managed care plans that would best serve their needs. But the consumer groups were all different and focused largely on advocacy, with which the center, as an objective organization and a neutral convener, could not involve itself. Because of these issues, the *Medicaid Managed Care Program* ended up investing substantially fewer resources in reaching consumer groups and addressing the consumer action agenda.

The *Medicaid Managed Care Program* awarded 29 grants to consumer and family-based organizations: 19 grants of up to $25,000 in 2001, and 10 grants of up to $50,000 in 2002.

Grant activities included:

- 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
- Developing peer-support services so consumers could help peers gain appropriate access to care

Organizations receiving grants under the consumer action agenda include:

- Gay Men's Health Crisis (New York), which developed a Medicaid Managed Care Consumer Collaborative to increase the participation of disabled Medicaid recipients in designing, implementing, and monitoring New York State's Medicaid managed care program

- Berkshire Health Education Center (Amherst, Mass.), which worked with rural community-based outreach programs to develop user-friendly, replicable materials to educate and support consumers about how to use publicly funded health care services

RWJF also gave 10 consumer action grants in 2001 to sites participating in its *Covering Kids & Families* national program, which was designed to find, enroll, and retain eligible children and adults in federal and state health care coverage programs. Read the Program Results Report on *Covering Kids & Families.*

Assessing the New Strategy and Evaluating the Program

In 2000, RWJF contracted with Mathematica Policy Research to provide an early assessment on the shift in strategy and the accomplishments and challenges of the *Medicaid Managed Care Program's* growing emphasis on technical assistance and training.[16]

The Early Assessment

Gold and other members of the evaluation team reviewed documents and interviewed participants in the programs managed by the *Medicaid Managed Care Program* (e.g., the first Purchasing Institute and the first Best Clinical and Administrative Practices Workgroup, the Managed Care Pricing Forum, and the consumer action agenda).

In a report submitted to RWJF in 2001, the evaluators noted strong support for the *Medicaid Managed Care Program*, especially from staff at state Medicaid agencies. The core audiences believed that the program provided an important product that was not otherwise available, especially the interactive forums (e.g., the Purchasing Institute and the Best Clinical and Administrative Practices Workgroup).

The report noted, however, that it was too soon to determine the ultimate effects of the new strategies and that future success would likely require developing a more integrated strategy that would create synergies among activities, for example, integrating grants and technical assistance.

The Assessment Leads to Reauthorization

Based on this assessment, in July 2001, the RWJF Trustees reauthorized the *Medicaid Managed Care Program* for three years at up to $10 million, including an evaluation of the program, also by Mathematica Policy Research.

Under the reauthorization, the Center for Health Care Strategies shifted even more of its resources from grantmaking to technical assistance and training, gave priority in its grantmaking to states and health plans that participated in the Purchasing Institutes or the

[16] Grant ID# 40121.

Best Clinical and Administrative Practices Workgroups, and targeted the grants in three priority areas:

- Managed care for children with special needs
- Managed behavioral and general health coordination
- Managed long-term care

The program awarded 20 grants (19 best practices grants and one model demonstration grant) selectively "to leverage new ideas" in projects on which state Medicaid agencies and Medicaid managed care plans were already working, says former program officer Rothman.

The Evaluation

The evaluation focused on the program years 2000–2003[17] so as to provide feedback on the outcomes of the *Medicaid Managed Care Program* and their implications for future quality improvement efforts. Evaluators used a two pronged-approach:

- A broad-brush view of how the core audiences perceived the *Medicaid Managed Care Program*
- An in-depth look at outcomes for the constituencies with which the program worked most closely

The evaluation was based on:

- Surveys of the Medicaid directors in all states, staff from Medicaid health plans, and representatives of consumer groups
- Interviews with participants in various *Medicaid Managed Care Program* activities
- Review of documents and program data and interviews with RWJF and Center for Health Care Strategies staff

For key evaluation questions and more information about the methods, see Appendix 3.

Evaluators at Mathematica Policy Research reported findings of the evaluation in "The Medicaid Managed Care Program," a chapter in RWJF's 2005 anthology, *To Improve Health and Health Care Volume IX*, and in a report to RWJF. The following key findings are excerpts from those reports:

Overall Evaluation Finding

- "Overall, the *Medicaid Managed Care Program* reached large sectors of its intended audiences between 2000 and 2003 with products that were well-regarded, and the

[17] Grant ID#s 45772, 46351, and 50352.

program's support led to concrete changes in the way some states and health plans delivered Medicaid managed care."

Findings About Program Reach, Participation, and Reputation

- **The states, Medicaid health plans, consumer groups, and other stakeholders were typically aware of CHCS and its work on Medicaid managed care.** Although they also relied on other sources for information, they thought that the *Medicaid Managed Care Program* provided a unique resource that focused on operational concerns in ways that were unavailable elsewhere. For example:
  - State Medicaid directors cited the following qualities as strengths of the center:
    - "Connections and competence"
    - "Breadth of experience"
    - Willingness "to try different things...to take risks and be demanding about what they [expect]"
    - "Institutional memory"
    - 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 Best Clinical and Administrative Practices Workgroups appreciated the "hard-to-find forum that speaks to the particular challenges and issues of the Medicaid population."
- **The *Medicaid Managed Care Program* reached a substantial share of states and health plans, two of its three target audiences**.
  - By 2003, at least 75 percent of the states had participated in a Purchasing Institute, or received a grant or technical assistance. Many states participated more than once and in multiple types of activities.
  - About 42 percent of Medicaid managed care plans, a newer audience for the program, participated in one or more program activities. Staff from health plans in which Medicaid made up a small share of total enrollment were less aware and thus these plans were less likely to participate in program activities.
- **States and health plans overwhelmingly rated the activities in which they participated as excellent or good.**
- **Awareness of the *Medicaid Managed Care Program* was high among other groups surveyed (staff from CMS, Medicaid policy analysts, and Medicaid managed care researchers).** This awareness was not deep, however, and these

groups tended to be most aware of the activities targeted to them rather than *all* program activities.

Findings about Changed Practices Among Core Audiences

- **Half of the 43 Medicaid directors interviewed made concrete improvements in their Medicaid managed care programs because of participating in the *Medicaid Managed Care Program*—indicating that they saw the program as fostering change and improvements in their state programs.**

  Although some changes involved hard-to-assess intangibles, such as providing ideas for new initiatives and validating state perceptions and strategies, the evaluators found evidence that at least 10 states made concrete, substantive improvements in their Medicaid managed care programs (all but one remained in place as of fall 2004 when the evaluation was completed).

  Improvements included:

  — The development and public reporting of health plan performance information

  — Changes to the way states oversee quality in Medicaid managed care

  — New ways of contracting and working with plans

  Specific examples of state improvements include:

  — Maryland evolved a "value-based purchasing strategy" for its Medicaid managed care program through participation in multiple Purchasing Institutes and on-site technical assistance. The strategy included monitoring performance goals and providing rewards for health plans meeting those goals,[18] and a consumer report card to give visibility to high-quality plans.

  — Indiana developed a managed care report card highlighting areas such as member satisfaction, quality of care, and access through its participation in a Purchasing Institute and on-site technical assistance. Reactions were positive, and the report card is now annual.

- **The health plans made changes in the way they delivered care based on their participation in the Medicaid Managed Care Program.**

  — The majority of health plans that participated in four of the first five Best Clinical and Administrative Practices Workgroups made changes. Most of these changes were still in place three to 12 months later, and some plans continued to make changes after the end of the workgroup.

[18] Unfortunately, Maryland could not make the reward payments because the funds reserved for them were taken out of Medicaid's budget.

— Most participants in the Best Clinical and Administrative Practices Workgroups changed their thinking about quality improvement and their approach to quality, including in clinical areas outside of the workgroups' focus.

Specific examples of health plan[19] changes include:

— One plan focused on improving early and periodic screening, diagnosis, and treatment rates for adolescents by providing incentives to both the adolescent health plan members and staff members at pilot community health centers.

— Another health plan targeted disabled beneficiaries with congestive heart failure or diabetes and other health conditions who lived in rural areas. Using telephone case management, the plan reduced hospitalization rates, length of stay, and total monthly costs per member by 47 percent.

Whether the changes have had a positive effect is hard to know. Most health plans struggled to track the outcomes of their interventions. Measuring change was harder for some issues, such as chronic disease in adults and birth outcomes, than for others, such as asthma and preventive care for children, which have a strong evidence base for interventions and accepted performance measures.

Health plans that made little progress or stopped participating tended to have turnover in leadership or staff, or both, or adverse financial circumstances. Organizational stability appears to be an important pre-condition for 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.

- **The *Medicaid Managed Care Program* was much less successful with consumer groups than with the states and health plans.** "Everyone knew consumers were an important audience but reaching consumers is really hard," said Gold.

  The consumer action grants left little mark on the environment, with grants too small, too localized, and too short to have a lasting effect on helping strengthen consumer and family members' capacity to navigate or assume a formal role in publicly financed managed care. Despite the lack of success, consumer groups reported this support as important and were disappointed that more grant funding was not forthcoming.

Findings about Overall Program Effectiveness

- The *Medicaid Managed Care Program's* integration of technical assistance and 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 how they purchase and provide Medicaid managed care.

[19] Plan names are omitted to protect their confidentiality.

Many participants said that the combination of technical assistance and grants was more effective than either one alone. This was truer for the states, which had more grant experience with the program, than for health plans.

- Through the *Medicaid Managed Care Program*, CHCS matured and gained respect, generating support and capacity that RWJF and other foundations can tap to pursue related work.
- There are areas where the *Medicaid Managed Care Program's* performance could be stronger.
  - In a field where leadership turns over frequently, the program has not been as aggressive as it might have been in working with newly appointed state officials.
  - Although measurement is crucial in quality improvement, health plans participating in Best Clinical and Administrative Practices Workgroups still struggle to develop valid measures to judge performance.
  - The program'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 program's focus on consumers, its third core audience, has been limited. Although many consumer groups are aware of it, the program has invested relatively little in initiatives to strengthen them.

Read the full report or summary of Mathematica Policy Research's evaluation of the *Medicaid Managed Care Program*.

The Program Continues to Evolve: Building Multi-Stakeholder Alliances and Supporting RWJF's Evolving Priorities

Alliances to Advance Medicaid Quality and Reduce Disparities

By about 2004, Medicaid's transformation from fee-for-service to managed care had been underway for a decade. The rancorous stakeholder relationships of the early years had given way to a far greater sense that "we're all in this together," according to Somers. Fruitful and trusting business partnerships had emerged and the difficult challenges of serving more Medicaid beneficiaries with complex needs required even more collaboration among state Medicaid agencies, managed care plans, and other stakeholders. The managed care plans that remained in the marketplace included large commercial plans that had a mix of Medicaid and private coverage products; large national and regional Medicaid-only publicly traded plans; and Medicaid-only not-for-profit plans. Increasingly, CHCS worked with Medicaid-only plans, whose staff members were familiar with the many complexities of this at-risk population.

These complexities included mental health and substance abuse problems among people living in poverty. Some were in jail, homeless, or in danger of becoming homeless.

"These complex populations had multiple needs beyond pure medical care, and multiple agencies needed to be engaged at the state and local levels," said Somers. "There were turf issues, funding stream issues, and a lack of understanding and knowledge across the respective areas." Also, managed care organizations did not know how to serve Medicaid beneficiaries with complex needs, according to Somers.

"This was a multidimensional, complex undertaking. You couldn't do it just with Medicaid agencies or managed care plans. You had to engage folks working with mental health and other issues as well," said Somers.

Quality improvement projects focused on multi-stakeholder collaboratives included the Regional Quality Improvement Initiative and the Business Case for Quality initiative.

Regional Quality Improvement Initiative

To improve chronic care throughout a region or state, key stakeholders must implement coordinated strategies at the purchaser, health plan, provider, and consumer levels. In 2006, CHCS launched the Regional Quality Improvement Initiative to leverage Medicaid's significant purchasing power to improve care for people with chronic conditions through partnerships with other health care leaders, including commercial insurers, employers, providers, and consumer organizations.

Rhode Island Chronic Care Sustainability Initiative

Rhode Island's Chronic Care Sustainability Initiative, developed through the Regional Quality Improvement initiative, was the first patient-centered medical home pilot in the country to gain the support and alignment of both public and private payers. A patient-centered medical home is a team-based model of care that replaces episodic treatment for illness with coordinated care and a long-term relationship with providers.

The Chronic Care Sustainability Initiative:

- Aligned quality improvement and financial incentives among Rhode Island's health plans, purchasers, and providers
- Improved primary care for patients with chronic conditions
- Enhanced the attractiveness and viability of primary care in Rhode Island.

In 2008, the Chronic Care Sustainability Initiative began supporting five physician practices with funding to help cover the costs of implementing and maintaining the patient-centered medical home and with technical assistance to evaluate and improve processes for managing patients with heart disease, depression, and diabetes. By October 2010, the pilot had expanded to 13 physician practices, 66 providers, 28 family medicine residents, 68,000 patients, and all Rhode Island payers (except fee-for-service Medicare).

Read more about this case study.

Four competitively chosen regions—Arkansas, North Carolina, Rhode Island, and Rochester, N.Y.—participated. Strategies included:

- Aggregating data and sharing performance information across payers
- Providing quality improvement tools, such as evidence-based guidelines and chronic care innovations, to help practices improve care delivery
- Aligning provider incentives with quality improvement and performance outcomes
- Engaging consumers in chronic care delivery by reporting outcomes and encouraging patient self-management

Lessons learned informed cross-payer health quality improvement efforts in other states and communities. CHCS developed many tools related to regional quality improvement, including webinars, issue briefs, and case studies.

Read more about this initiative and related resources.

Business Case for Quality in Medicaid Managed Care

The lack of evidence of a financial return on investment from interventions to improve

Johns Hopkins Makes the Business Case for Integrated Medical and Substance Abuse Care

Johns Hopkins HealthCare, a Maryland-based health plan, brought together disease and behavioral care management for Medicaid recipients with a substance abuse diagnosis and chronic conditions. It then determined whether this approach provided a return on the investment

Staff examined the first 12 months of claims histories of 603 adult Medicaid enrollees who frequently used medical services and had a recent history of substance abuse. They put 400 of these people in the intervention group, which received integrated medical case management and substance abuse treatment from substance abuse coordinators and nurse care managers. The comparison group, the remaining 203 people, received routine care: separate outreach from substance abuse coordinators and care managers.

The initial results appear to be both clinically and financially significant to Johns Hopkins, as well as to other organizations considering similar initiatives. For the intervention group, medical costs decreased $122 per member per month, while costs for the comparison group increased $165, compared to the prior 12 months. Enrollment in substance abuse treatment and case management increased for the intervention group.

Johns Hopkins HealthCare reported that with sustained effort, integrated care management of medical and substance abuse services could result in a positive return on investment, reduced hospital stays, and a high level of quality care.

Read more about this case study.

health care quality was hampering improvements in the quality of Medicaid services by organizations making the investment. To develop this evidence, CHCS staff collaborated with evaluators at the University of North Carolina School of Public Health and Mathematica Policy Research on the Business Case for Quality in Medicaid Managed Care initiative.

The initiative's first phase, launched in 2004, tested whether Medicaid managed care organizations could make a business case for quality. CHCS funded 30-month demonstration projects run by 10 organizations: eight Medicaid managed care organizations, one state primary care case management program, and one external quality review organization. The projects included:

- Evidence-based projects on asthma, diabetes, and prenatal care
- Projects to address the needs of populations with multiple chronic illnesses, including:
  - Coordinated services for adults with complex needs
  - Long-term care services for dual eligible (Medicare and Medicaid) recipients

Evaluation results showed a positive return on investment for three of the interventions implemented. Results suggested that the following intervention characteristics offered greater likelihood for demonstrating short-term financial returns:

- Stratifying high-cost, high-risk populations for intervention
- Focusing on certain conditions for short-term return on investment potential, such as severe childhood asthma and high-risk pregnancy
- Focusing on conditions linked with avoidable acute care utilization

Read more about the first phase of this initiative and related resources.

In 2008, CHCS launched the second phase of the Business Case for Quality in Medicaid Managed Care initiative, which focused on developing rigorous evidence interventions that improve quality and reduce costs for treating high-risk childhood asthma. Three competitively chosen grantees participated:

- Alameda Alliance for Health, a Medi-Cal (Medicaid) managed care plan serving children in Alameda County, Calif.—in partnership with the Children's Hospital & Research Center-Oakland, the Alameda County Health Department, the American Lung Association of California, and local providers—implemented Asthma Tools and Training Advancing Community Knowledge (ATTACK).

  Staff referred children to an adjacent ATTACK clinic following an emergency department visit for asthma. A physician or nurse practitioner then did an asthma

assessment, provided treatment and one-on-one education, and developed an asthma action plan for the child and parent/guardian. An on-site caseworker linked families to community resources (e.g., school-based self-management education).

- Cincinnati Children's Hospital Medical Center led a multi-stakeholder collaborative that included two health plans (CareSource and Amerigroup), provider groups, and local school systems, and focused on eliminating asthma-related admissions and emergency department/urgent care visits for children in Hamilton County with asthma and Medicaid coverage. The intervention included:
  - Care coordination, with an initial focus on the inpatient to outpatient transition
  - Self-management support, through community-based case management
  - Reduction of physical and social environmental barriers to care through risk assessments and linkages with community supports
- Monroe Plan for Medical Care, a Medicaid managed care plan serving Rochester, N.Y., and surrounding communities, worked with the New York State Department of Health and several regional health care delivery networks to implement a pay-for-performance initiative to improve care for children with asthma.

  This initiative aligned financial incentives to potentially increase provider compliance with evidence-based asthma guidelines. Providers in participating clinics received payments for providing enhanced asthma care, including use of asthma action plans and self-management education.

Each grantee received funding, as well as training and technical assistance on quality improvement, program evaluation, and return on investment analysis.

The evaluation did not show a positive return on investment, but there were promising signs that the sites produced positive intermediate outcomes. The findings demonstrated that achieving a business case is difficult—particularly for newly established interventions, with their unanticipated challenges and need to implement process improvements, and the time lag between making the improvements and impacting health care use and producing financial gains.

Alameda Alliance for Health and Cincinnati Children's Hospital Medical Center sustained their interventions after the initiative ended, reflecting leadership buy-in that the work improved patient care and might eventually yield a return on investment.

CHCS developed many tools related to the business case for quality in Medicaid managed care, including an issue brief, a case study, and a Medicaid Return on Investment Template tool. Read more about the second phase of the initiative and related resources.

Multi-Stakeholder Initiatives to Reduce Disparities

Beginning in 2004, CHCS focused significant *Medicaid Managed Care Program* resources toward eliminating disparities in care. The program began to help states and health plans identify opportunities to improve the quality of care for racially and ethnically diverse populations and at the same time raise the bar for the provision of high-quality, evidence-based care for *all* Medicaid beneficiaries. All of the initiatives to reduce disparities sought to align political, programmatic, and financial leverage to improve care for populations experiencing disparities in care.

Small primary care practices play a critical role in caring for Medicaid recipients from diverse racial and ethnic groups. The Reducing Disparities at the Practice Site initiative supported quality improvement in small practices serving these beneficiaries from 2008 to 2010.

Medicaid agencies in Michigan, North Carolina, Oklahoma, and Pennsylvania worked with health plans and small practices to build the quality infrastructure and care management capacity of these primary care practices. With technical assistance from CHCS and experts in the field, practice sites implemented interventions focused on:

- Tracking patients and outcomes using an electronic data management tool
- Adopting evidence-based guidelines for targeted chronic conditions
- Incorporating team-based care into practice operations

This work identified critical opportunities where state Medicaid agencies can leverage resources to facilitate and sustain improvements in care and reduce disparities in small, under-resourced practices with many Medicaid patients. For example, state Medicaid agencies could:

- Use claims and race/ethnicity/language data to identify small practices with a large number of Medicaid and racially diverse patients and focus resources on these practices to improve care for many Medicaid patients
- Partner with Medicaid health plans, other payers, regional quality coalitions, universities, and other entities to ensure that quality improvement resources, such as technical assistance and learning collaboratives, reach small, high-volume Medicaid providers

Read more about this initiative and related resources.

Supporting RWJF's Evolving Priorities

Over time, as RWJF revised its goals, funding around Medicaid issues became less of a focus. Yet, the Foundation continued to support the *Medicaid Managed Care Program* until November 2012. Some of CHCS' work during this period reflected RWJF's new

priorities, says Anne F. Weiss, MPP, RWJF director of the Quality/Equality team and senior program officer. "The terms of the RWJF support gave center staff members a fair amount of flexibility to use their expertise and platform and capacities to design initiatives. Where possible, they reinforced the themes important in the Foundation's strategy," she said.

For example, CHCS' Regional Quality Improvement Initiative reinforced RWJF's regional market-based strategy in its program, Aligning Forces for Quality. This is RWJF's signature effort to lift the overall quality of health care in 16 targeted communities, reduce racial and ethnic disparities, and provide models for national reform.

Another important part of the Foundation's quality strategy is encouraging providers to use racial and ethnic data and look for opportunities to reduce disparities. CHCS' Reducing Disparities at the Practice Site initiative taps into that.

RWJF has also turned to CHCS for assistance with some of its other work. The *Medicaid Leadership Institute,* started in February 2009, grew out of the *Medicaid Managed Care Program,* says Somers. CHCS is the national program office for this fellowship program for state Medicaid directors. Read the Progress Report about the *Medicaid Leadership Institute.*

CHCS also provides technical assistance for RWJF programs, including:

- *Aligning Forces for Quality*: CHCS has been helping to engage Medicaid stakeholders in *Aligning Forces for Quality* since November 2008. This includes:
  - Connecting the *Aligning Forces for Quality* communities with Medicaid leaders
  - Building Medicaid state and health plan capacity to support practice improvement
  - Helping commercial health plans collect race, ethnicity, and language data
- *State Health Reform Assistance Network*: The network provides technical assistance to states to maximize coverage expansion under the Affordable Care Act. In June 2011, the CHCS became one of the technical assistance providers for the network.

Communicating Program Results

Spreading and replicating best practices and providing real-time analysis to facilitate decision-making for Medicaid policy-makers have been underlying communications goals of the *Medicaid Managed Care Program* since its inception. CHCS staff developed and shared relevant publications and toolkits to disseminate lessons learned from the program among Medicaid stakeholders nationally.

Communication products included:

- A robust website[20]
- Publications, including environmental scans, resource papers, toolkits, policy briefs, project spotlights, and fact sheets
- A national webinar series
- Presentations at conferences and meetings
- An e-newsletter

See the Partial National Program Office Bibliography for details.

Highlighting the Complexities of Caring for High-Need, High-Cost Populations

The Faces of Medicaid research series shed light on the complexity of Medicaid's high-need, high-cost recipients and the challenges in designing cost-effective care systems for them. The Center for Health Care Strategies published five Faces of Medicaid analyses to help Medicaid stakeholders identify subsets of patients or conditions that are most likely to benefit from care management.

The studies used national claims and pharmacy data to examine Medicaid's highest-need, highest-cost populations. They pinpointed areas of opportunity to help states and health plans better focus resources to improve care and reduce unnecessary hospital and emergency room utilization.

The series titles were:

- *The Faces of Medicaid: The Complexities of Caring for People with Chronic Illnesses and Disabilities* (November 2000)
- *The Faces of Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions* (October 2007)
- *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions* (October 2009)
- *Faces of Medicaid: Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations* (December 2010)
- *Hospital Readmissions among Medicaid Beneficiaries with Disabilities: Identifying Targets of Opportunity* (December 2010)

The Center for Health Care Strategies also sponsored a national webinar on each Faces of Medicaid analysis and provided related resources. The Faces of Medicaid analyses attracted considerable state and national attention.

[20] The website no longer exists separately from the Center for Healthcare Care Strategies (CHCS) website; products from the program are integrated into lists of other CHCS products, by topic.

Sustaining the Work

From the beginning, CHCS planned to sustain its work after RWJF's funding for the *Medicaid Managed Care Program* ended. CHCS' focus on performance improvement in Medicaid managed care and providing technical assistance to help states and managed care plans build their capacity was a key part of the strategy to attract other funders.

"That is exactly what happened," said former program officer Rothman. "We were having a much bigger impact than just the Foundation's investment itself."

The California HealthCare Foundation is one of those other funders. "The center has been a unique resource for us," said the California HealthCare Foundation's Chris Perrone, deputy director of its Health Reform and Public Programs Initiative. "It has a reservoir of knowledge and relationships that doesn't exist with other consultants." The way that the center shares best practices, analysis, and other information so that anyone can use it is unique, he notes.

By November 2012, when the *Medicaid Managed Care Program* ended, CHCS had used the RWJF funding to leverage $57 million for related projects, including funding from other foundations, corporate philanthropy, as well as federal agencies, including CMS and the Agency for Healthcare Research and Quality.

SIGNIFICANCE OF THE PROGRAM

As described below, the *Medicaid Managed Care Program* has contributed to Medicaid's transformation into a quality health insurance program by helping state Medicaid agencies to become better purchasers of health care and managed care plans to deliver better care to Medicaid beneficiaries.

Through the *Medicaid Managed Care Program*, CHCS has become the go-to resource for guidance to these and other stakeholders on organizing, financing, and delivering high-quality, publicly financed care. It played a role in shaping, and now implementing, health reform. CHCS also informs RWJF's work and provides technical assistance related to Medicaid on some of the Foundation's programs and projects.

Enhancing the Reputation of Medicaid—and Managed Care within Medicaid

Medicaid has made progress, and the *Medicaid Managed Care Program* helped drive that progress. "Its reputation and its potential to be a mainstream part of the American health care system are vastly better," says RWJF's Weiss. "It has moved from being seen as a stigmatized public welfare program to being viewed as an insurance program much like other health insurance programs—although because it is such a poor payer, Medicaid is still viewed skeptically by some providers," notes Weiss. "Medicaid's been put on

steroids in terms of funding and shaping the health care system. It is now very much about quality," said Nancy Barrand, MPA, RWJF senior adviser for program development.

In addition, Medicaid managed care has become mainstream, thanks in large part to the RWJF imprimatur, says national advisory committee member Robert Hurley, PhD. The Foundation's support for Medicaid managed care "illustrated that this was no longer, as conventionally viewed, a punitive strategy in Medicaid, it was a progressive strategy. It made Medicaid managed care respectable in a way it had not been previously."

Building Capacity in States and Managed Care Plans

CHCS and the *Medicaid Managed Care Program* gave states and managed care plans the in-depth technical assistance, training, and resources they needed to effectively implement managed care in Medicaid, in a safe, neutral setting where they could learn from each other.

Through the *Medicaid Managed Care Program*, CHCS built "unique expertise in how to improve Medicaid performance, to help a state take an individual approach to purchasing benefits and help health plans design and execute programs to improve care experience, quality, and efficiency," said Rothman. The result was a high level of engagement and innovation in Medicaid managed care by states and managed care plans.

CHCS' hands-on approach focused on turning ideas into actions that states and health plans could take to improve their operations. "It created safe havens between the plans and the states so they could talk to each other to figure out better approaches," said Barrand.

Bringing the players together to work through issues was key, says Sara Rosenbaum, JD, a member of the national advisory committee. "This is a very high stakes proposition. It was going to be billions of dollars in federal Medicaid spending to do a transformational thing: to give people a membership in a health care system that would deliver what it got paid for." Rosenbaum is the Harold and Jane Hirsh professor in the School of Public Health and Health Services at George Washington University.

The center's contributions to Medicaid managed care were especially significant in highlighting the need for quality and performance measurement in Medicaid managed care and in advancing understanding of the challenges of managed care for Medicaid beneficiaries with complex, chronic conditions.

The biggest change resulting from the *Medicaid Managed Care Program*, says Hurley, is that the states are much better purchasers of care, which has resulted in health plans delivering better, more responsive care. "It's a more vibrant marketplace today with meaningful measures of performance," he said.

Adds RWJF's Weiss, "By engaging states at a very granular level, the center had an impact on helping states give better care and control costs for a very vulnerable population."

Rothman and Somers note that the program's focus on implementing policy changes was crucial. "Unless there's help for those implementing policy changes, it's not going to be successful," said Somers. Delving into the "dirty implementation end of the work helped people at the leadership level in foundations and in the policy world understand how much implementation matters," added Rothman.

Becoming the Go-To Resource on Medicaid

For the Field

Although the *Medicaid Managed Care Program* itself has ended, the Center for Health Care Strategies remains the "go-to" resource for implementation guidance on organizing, financing, and delivering high-quality, publicly financed care, especially for those with complex, chronic conditions.

"If you want to have an impact on the low-income population's health care and your focus is on performance improvement, there is nowhere else you should go," said Rothman.

"The center is a unique resource," added California HealthCare Foundation's Perrone. "I value the unique role it plays in Medicaid managed care and Medicaid policy more broadly."

For RWJF's Work

The expertise and high-quality reputation of CHCS, along with its extensive network with the states and health plans, gives RWJF easy access to "expertise that we otherwise would have to find elsewhere from many different sources," says Barrand.

Along with its work on RWJF programs already described (*Medicaid Leadership Institute*, *Aligning Forces for Quality*, and *State Health Reform Assistance Network*), CHCS provides technical assistance to other RWJF programs and projects in areas related to Medicaid. RWJF also turns to CHCS to convene workgroups and provide other information to inform the Foundation's work.

"If I have a question on Medicaid or if I have a grantee who needs some expertise on Medicaid, they are the go-to source. That's what we set them up to be and that's what they've proven to do well," said Barrand.

Shaping Health Reform and Assisting in Implementation

The work of the *Medicaid Managed Care Program* has permeated the field, says Somers, including contributing to elements of the Affordable Care Act. The program's work on integration of care for people eligible for both Medicaid and Medicare and on care coordination for populations with complex, chronic conditions contributed to the establishment of the Medicare-Medicaid Coordination Office and the focus on Health Homes, respectively, in the act.

Health Homes are an optional Medicaid state plan benefit to coordinate care for people with chronic conditions that use a "whole-person" philosophy. Health Home providers will integrate and coordinate primary, acute, behavioral health, and long-term services and supports. "These are significant elements in the legislation you can trace back in one form or another to activities of the *Medicaid Managed Care Program*," said Somers.

With funding from the federal government, CHCS is now providing technical assistance to states on the implementation of Health Homes and the integration of care for people who receive both Medicaid and Medicare. For more information about this, see Afterward.

RWJF's Weiss also notes, "The Center for Health Care Strategies' role in implementing major federal initiatives is noteworthy. That's way beyond where we were when I got involved in this program."

CHALLENGES AND LESSONS LEARNED

The Center for Health Care Strategies experienced two main challenges in managing the *Medicaid Managed Care Program*:

- Politics and poor economic conditions often hamper innovation and improvement in Medicaid; when more people qualify for Medicaid, states have less money to spend on improving the program. Managing a foundation program that ran for 17 years meant coping with gubernatorial elections at least every four years and practically guaranteed several economic downturns and upturns. In 2010, for example, there were 30 gubernatorial elections and many disruptive party changes.

  When these things occurred, staff at CHCS reminded themselves and their Medicaid partners that adversity can bring opportunity and ramped up technical assistance to stakeholders on pressing issues.

- Discovering technical assistance providers that state Medicaid officials would find familiar and trustworthy required recruiting people with relevant state-level experience. Thus, CHCS had to build a team of former state Medicaid officials who served as virtual technical assistance providers.

The move by some former staff members into leadership positions in New Jersey, Oregon, Rhode Island, Virginia, and at CMS has also been helpful. This kind of interconnectivity has allowed CHCS to "cut to the quick" in identifying and resolving challenging issues in managed care and in Medicaid more broadly.

Lessons from the National Program Office

Program director Somers provided the following lessons.

1. **Establish a presence in the field**. CHCS and the *Medicaid Managed Care Program* cast a wide grantmaking net and provided relevant resources and technical assistance for multiple stakeholders.

2. **Find a "blue ocean"—an unoccupied niche of salience to the field—and become the leader in that niche**. CHCS identified helping states implement Medicaid managed care as a niche it could own and in which it could strategically develop expertise. "Find things that need to be done and go in there no holds barred," said Somers.

3. **Facilitate collaboration among multiple stakeholders through neutrality and balance.** States and health plans learned from each other and worked together because they saw CHCS as a neutral organization that provided a safe haven for them to work together.

4. **Adapt as the field evolves and be prepared to adjust focus and tactics to continue to provide value-added services**. When grantmaking turned out not to be the most effective strategy for the *Medicaid Managed Care Program,* staff shifted to intensive technical assistance. This required recruiting new kinds of staff as technical assistance providers. Similarly, as state relationships with their contracted plans matured and plans became more familiar with the Medicaid population, CHCS reengineered the level and type of technical assistance it provided, e.g., shifting from a single stakeholder to a multiple stakeholder focus.

5. **Ensure sustainability by diversifying sources of funding and finding unoccupied niches of salience to the field.** From the beginning of the *Medicaid Managed Care Program,* Somers knew that he would have to raise money from other funders to continue the work. "I used my Robert Wood Johnson Foundation experience and connections and RWJF's goodwill with other foundations—and its interest in seeing partnerships develop—to develop other relationships," he said.

   CHCS also found other areas that were important to the field, including work on quality improvement and disparities in care, and work on integration of care for people dually eligible for Medicaid and Medicare.

6. **Support effective communications to cement a program's reputation, spread best practices, and establish a public niche.** Communications played a key role in CHCS' work on the *Medicaid Managed Care Program.* The center built its reputation

by developing and sharing operationally relevant publications and toolkits with Medicaid stakeholders nationally.

7. **Set goals with program-specific benchmarks to obtain buy-in, measure progress and performance, and work with evaluators**. By setting goals with benchmarks related to the various initiatives offered by the *Medicaid Managed Care Program*, CHCS was able to obtain buy-in and a common understanding among program staff members, develop a structure for measuring progress and performance, and coordinate its work with RWJF program evaluation efforts.

Lessons from the Evaluation of the *Medicaid Managed Care Program*

Marsha Gold, program evaluator, reported the following additional lessons:

8. **Evaluate technical assistance by distinguishing a program's reach from its outcomes, with more focus on outcomes for the core audiences.** Evaluating technical assistance is difficult as there are no clear outcomes. Evaluators at Mathematica Policy Research believed that blending a broad-based survey of the core audiences to learn about the *Medicaid Managed Care Program's* reach with more in-depth work with participants in selected activities to study outcomes was effective.

9. **Settle on the key evaluation questions early for broad-based programs with general goals.** By settling on the key evaluation questions from the outset, the evaluators were able to distinguish the reach of the *Medicaid Managed Care Program* from its outcomes.

AFTERWARD

CHCS continues to work closely with most states to help Medicaid deliver higher quality, more cost-effective services for low-income Americans.

The center continues to use the Best Clinical and Administrative Practices Workgroup approach in many of its initiatives. Many health plans, such as Affinity Health Plan (Bronx, N.Y.), Network Health (Boston), Monroe Health Plan (Buffalo, N.Y.), and Partnership Health Plan of California (Fairfield) have institutionalized the approach to guide their quality improvements efforts.

Almost all of the center's work has its roots in the *Medicaid Managed Care Program*, which has enabled the center to secure funding from RWJF, other foundations, and the federal government.

Work on Other RWJF Programs

CHCS continues to work on RWJF programs: *Medicaid Leadership Institute, State Health Reform Assistance Network, Aligning Forces for Quality*, as well as work linking supportive housing with Medicaid, and technical assistance to help New Jersey's

Medicaid agency transform its program, among other efforts (as of March 2013). The *Medicaid Leadership Institute* and the technical assistance to grantees under the *State Health Reform Assistance Network* have their roots in the *Medicaid Managed Care Program's* Purchasing Institutes and the Managed Care Pricing Forum.[21]

The center's work on delivery system and payment reform grows out of the *Medicaid Managed Care Program's* Best Clinical and Administrative Practices Workgroups and from subsequent work providing technical assistance under RWJF's *Aligning Forces for Quality* program.

Read more about these programs:

- *Medicaid Leadership Institute* (and the Progress Report)
- *State Health Reform Assistance Network*
- *Aligning Forces for Quality*

Work with the Federal Government

CHCS provides technical assistance to states through five federal programs: the Integrated Care Resource Center; the Health Home Information Resource Center; the State Innovation Models Initiative (as of March 2013); the Medicaid and CHIP Learning Collaboratives; and the Medicaid Managed Care Technical Assistance Center.

Integrated Care Resource Center

The Integrated Care Resource Center helps states deliver coordinated care for Medicaid's high-need, high-cost beneficiaries, with the goal of improving the quality and reducing the costs of care. It is a joint project of the CMS Medicare-Medicaid Coordination Office and CHCS. Since September 2011, CHCS has worked with Mathematica Policy Research on a project to provide technical assistance to states on developing integrated models of care for people dually eligible for Medicaid and Medicare.

Health Home Information Resource Center

CMS established the Health Home Information Resource Center to help states develop Health Homes to coordinate medical, behavioral health, and long-term services and supports for Medicaid beneficiaries with chronic health problems. The 2010 Affordable Care Act established health homes as an option under Medicaid. CHCS is working with

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[21] In addition, CHCS served as the national program office for three other RWJF programs:

- *Building Health Systems for People with Chronic Illness.* See Program Results Report.
- *Improving Asthma Care for Children.* See Program Results Report.
- *State Action for Oral Health Access.* See http://www.rwjf.org/en/library/research/2007/11/state-action-for-oral-health-access.html.

Mathematica Policy Research to provide the technical assistance to states on issues in developing and implementing health homes.

State Innovation Models Initiative

The CMS State Innovation Models Initiative is providing up to $300 million to support the development and testing of state-based models for transforming the payment and delivery systems in Medicare, Medicaid, and CHIP in 25 states. CHCS is providing technical assistance to the states.

The Medicaid and CHIP Learning Collaboratives

CHCS established the Medicaid and CHIP Learning Collaboratives (the MAC Collaboratives) to help states and their federal partners work together to achieve high-performing state health coverage programs. Over a two-year period, a series of collaborative workgroups brought states and CMS partners together to address critical topics for establishing a solid health insurance infrastructure. CHCS works with Mathematica Policy Research and Manatt Health Solutions to coordinate the collaboratives.

Medicaid Managed Care Information Resource Center

CMS created the Medicaid Managed Care Information Resource Center to help address the needs of the growing population of Medicaid beneficiaries, including many with complex needs. CHCS provides direct technical assistance to states and coordinates a national webinar series addressing critical Medicaid managed care topics for an audience of states and CMS staff.

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APPENDIX 1

Partial List of Other Funders of the Center for Health Care Strategies Leveraged by Its *Medicaid Managed Care Program* Work

(Current as of the time of the grant; provided by the grantee organization not verified by RWJF.)

- Aetna Foundation
- Agency for Healthcare Research & Quality
- American Public Human Services Association
- American Academy of Pediatrics
- Annie E. Casey Foundation
- Atlantic Philanthropies.
- California Endowment
- California HealthCare Foundation
- California Institute for Mental Health
- California Managed Risk Medical Insurance Board
- Center for Medicare and Medicaid Innovation
- Centers for Medicare & Medicaid Services
- Children's Futures
- Colorado Foundation
- Commonwealth Fund
- Community Oriented Correctional Health Services
- DentaQuest Foundation
- Evercare
- JEHT Foundation
- Kaiser Permanente Community Benefit
- National Center on Addiction and Substance Abuse
- National Governors Association
- National Quality Forum

- New York State Health Foundation
- Nicholson Foundation
- Massachusetts Medicaid Policy Institute, a program of the Blue Cross Blue Shield of Massachusetts Foundation
- Mathematica Policy Research
- Milbank Memorial Fund
- Oregon Health and Science University
- David & Lucile Packard Foundation
- SCAN Foundation
- Substance Abuse and Mental Health Services Administration
- United Hospital Fund

APPENDIX 2

National Advisory Committee

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Joseph P. Anderson
Chairman and Chief Executive Officer
Schaller Anderson
Phoenix, Ariz.

Richard J. Baron, MD
President
Greenhouse Internists
Philadelphia, Pa.

Karen Scott Collins, MD
Vice President
New York Presbyterian Hospital
New York, N.Y.

Foster C. Gesten, MD
Medical Director
New York State Department of Health
Albany, N.Y.

Rhonda M. Johnson, MD, MPH
Medical Director
Highmark Blue Cross Blue Shield
Pittsburgh, Pa.

Robert J. Master, MD
President
Commonwealth Care Alliance
Boston, Mass.

Lynn V. Mitchell, MD
Medicaid Director
Oklahoma Health Care Authority
Oklahoma City, Okla.

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Senior Fellow
Mathematica Policy Research
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APPENDIX 3

Evaluation Methodology

Key Evaluation Questions

1. What does the *Medicaid Managed Care Program* aim to do, and how has the program evolved over its history?
2. Is the *Medicaid Managed Care Program* regarded as a valuable resource by its key audiences—states, plans, and consumer organizations—and what is its general reputation among key stakeholders?
3. Has the *Medicaid Managed Care Program* helped states become better purchasers, especially with respect to value-based purchasing? Are changes likely to endure?
4. Has the *Medicaid Managed Care Program* helped health plans improve the care they provide in the areas that the Medicaid Managed Care Program targets? Are changes likely to endure?
5. Have consumer grants been effective in accomplishing the consumer action agenda? What are the accomplishments?
6. What have been the respective contributions of grants and direct technical assistance to the *Medicaid Managed Care Program's* effectiveness? Does the leveraging of grants with technical assistance work better than awarding grants independently through solicitations?
7. Would *Medicaid Managed Care Program* users be willing to contribute to the costs of assistance provided by CHCS and under what conditions?
8. What does the *Medicaid Managed Care Program's* experience imply about the value, importance, and expected accomplishments derived from future program funding? What are the *Medicaid Managed Care Program's* strengths and weaknesses, and which areas deserve the most support?
9. What lessons can be drawn from the *Medicaid Managed Care Program* experience about foundation grantmaking that involves a technical assistance component?

Methodology

The evaluators:

- Surveyed and interviewed state Medicaid directors and other senior staff, staff at Medicaid health plans, and representatives of consumer groups to learn how well the audiences know the program and how they assessed the program and its importance to state policy goals. The evaluators conducted:
  - Telephone interviews with each state Medicaid director

  - Mail surveys with telephone follow-up of key senior staff involved with managed care in each state Medicaid program
  - Mail surveys with telephone follow-up of all participating Medicaid health plans nationwide and consumer advocacy organizations
  - A brief survey that included other stakeholders who were not part of the core audience groups
- Targeted interviews with participants in various *Medicaid Managed Care Program* activities to determine if these activities led to concrete changes. Evaluators interviewed:
  - State Medicaid directors in 43 of the 49 states that had Medicaid managed care programs
  - Health plan participants in the best clinical and administrative practices workgroups
  - Recipients of the consumer action grants
- Review of documents and program data and interviews with RWJF and Center for Health Care Strategies staff to understand the program's evolution. Evaluators also attended some of the meetings sponsored by the *Medicaid Managed Care Program*.

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