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Evaluation of the Medicaid Managed Care Program of the Center for Health Care Strategies: Overview of Results

Final Report

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EXECUTIVE SUMMARY

The Robert Wood Johnson Foundation (RWJF) established the Medicaid Managed Care Program (MMCP) in 1995 with the goal of using Medicaid's shift to managed care to improve care for vulnerable populations served by Medicaid. Over time, MMCP, based in an organization created explicitly for MMCP and called the Center for Health Care Strategies (CHCS), evolved from a traditional grant program focused on chronically ill populations to a major program of technical assistance that aims to work with states, health plans, and consumers to encourage "cutting-edge" innovations. The goal is to help states evolve into more informed purchasers of Medicaid managed care and to assist plans that seek to generate quality improvements in clinical and administrative practices. Since its inception, RWJF has awarded CHCS $62 million to support MMCP through mid 2007. (See Chapter 1 for additional context and description.) To provide feedback on the outcomes of the program and their implications for future efforts in quality improvement, RWJF funded Mathematica Policy Research (MPR) to conduct an evaluation of MMCP as it has operated since 2000.

MPR's evaluation uses several data sources to address a variety of questions. We conducted surveys of three core audiences—all states, Medicaid health plans, and diverse consumer groups to learn how well the audiences know the program and how MMCP's three key audiences assess the program and its importance to state policy goals. We carried out targeted interviews with participants in various MMCP activities to determine if the activities have led to concrete changes. We reviewed documents and program data to understand the program's evolution and undertook a variety of other analyses to provide targeted insight into particular areas. This report provides an overview of the evaluation's major findings and conclusions. The executive summary briefly reviews key findings and conclusions. Readers can find a more extensive summary in the last chapter of this report (Chapter 9).

SUMMARY OF MAJOR FINDINGS

What Does MMCP Do and How Has the Program Evolved Over Its History?

MMCP has evolved substantially over the course of its history. Indeed, CHCS views the ability of MMCP to do so as a core part of the program, enabling it to stay on the "cutting edge" and to foster innovation in a changing marketplace. The technical assistance that is promoted by MMCP involves a variety of types of help that is much broader than traditional one-on-one assistance. MMCP sponsors Purchasing Institutes that are attended by teams of state Medicaid personnel. The Best Clinical and Administrative Practices (BCAP) workgroups involve groups of health plans working over time to generate change as important foci for its work and to identify ways to help target change. MMCP aims to use one-on-one site visits, written materials that include toolkits and resource materials, grants (typically small and targeted), and peer communication through listservs and other Web-based tools synergistically to support change. Many of the products and skills developed by MMCP are applied in programs funded independently, both by RWJF and others. While RWJF may have funded MMCP as a distinct program, neither CHCS nor the core audiences for the most part make the distinction.

Is MMCP Regarded As a Valuable Resource by Its Key Audiences—States, Plans, and Consumers—and What Is Its General Reputation Among Stakeholders?

The core audiences and other stakeholders in Medicaid managed care generally are aware of CHCS and its work in Medicaid managed care. While the core audiences rely on other sources of information, they perceive MMCP as a provider of a unique resource not otherwise available to provide practical advice and help on operational issues.

MMCP has reached a substantial share of two of its three target audiences. At least 75 percent of states have participated in Purchasing Institutes, grants, and/or technical assistance activities. Thirty percent of Medicaid managed care plans nationwide participated in one or more plan-focused MMCP activities (BCAP workgroups and workshops, Quality Summit, grants, or technical assistance). Participants generally rate the activities highly. MMCP serves Medicaid-dominant plans more than commercial plans.

Has MMCP Helped States to Become Better Value-Based Purchasers, and Are Changes Likely to Endure?

The findings from the evaluation are encouraging. They show that half of all Medicaid program directors say that they made concrete improvements in their Medicaid managed care programs as a result of participation in MMCP. While some report intangibles that are hard to prove, like changing perceptions and reinforcing state activities, we found evidence that at least ten states made concrete, substantive improvements in their Medicaid managed care programs as a result of activities and interactions with MMCP. All but one of these improvements was implemented and remained in place by fall 2004. Strong Medicaid director support was critical to many of these successes but the changes endured after turnover if directors were in place long enough to institutionalize the change. But the findings also suggest that CHCS can be much more proactive in engaging new Medicaid directors early in their tenure. Support for states in this effort involved substantial investment from MMCP with states receiving a variety of kinds of assistance.

State surveys conducted by Harvard University show that Medicaid programs have become more sophisticated purchasers over the time MMCP has been in place, though this reflects many influences and cannot be attributed specifically to MMCP. Our analyses of the Harvard data, by state, show that those targeted by MMCP tend to have at least moderate sophistication (as intended by the program) but successful states also span a spectrum of sophistication levels.

Has MMCP Helped Health Plans Improve the Care They Provide, and Are Changes Likely to Endure?

Health plans participating in MMCP's health plan-related activities credit these activities with improving the way they deliver care. When we looked in depth at subsets of plans that received the most support (as a result of their participation in BCAP workgroups), we found that the majority of plans in each workgroup succeeded in implementing change and that most of these appeared positioned to sustain these changes in the future. Plans also reported that BCAP had changed the way they think and resulted in other plan changes. However, fewer plans were able to track the outcomes of their interventions, and experience with process measures varied

across BCAPs. When logic models for intervention and measurement were absent, plans seemed to struggle most. In addition, plans that faltered often experienced turnover in leadership and/or staff and adverse financial circumstances, conditions over which MMCP has little influence.

What Are the Accomplishments Under the Consumer Action Agenda, and Have Grants Been Effective in Moving It Forward?

MMCP has been much less successful with its third core audience—consumer groups. The Consumer Action grants have left little mark on the environment, with grants too small, too localized, and of duration too short to have a lasting effect on helping strengthen consumer and family members' capacity to navigate publicly financed managed care or assume a formal role in designing, implementing, and monitoring managed care programs. Consumer groups see a need for such support and would welcome it from MMCP.

What Have Been the Respective Contributions of Grants and Direct Technical Assistance to MMCP's Effectiveness, and Does Leveraging Grants with Technical Assistance Work Better Than Awarding Grants Independently Through Solicitations?

Our evaluation involved a period in which MMCP increasingly integrated grants with technical assistance activities and also moved to smaller grants. Evaluation findings support MMCP's thrust toward leveraging grants with technical assistance. Core audiences find each activity important and those receiving both were particularly positive. The role that grants have played within states suggests that MMCP may want to consider retaining the capacity to award larger grants when such grants can contribute the long-term success of specific planned changes and have leadership support but no other access to needed investment capital.

Would MMCP Users Be Willing to Contribute to the Costs of Assistance Provided by MMCP and Under What Conditions?

States and health plans participating in MMCP view the program as important and the technical support it provides to be strong and of considerable value. Directors in most states also envision that some form of Medicaid managed care is likely to remain important in the future as states address their fiscal constraints. Hence, ongoing help is likely to be important. But evaluation findings on user's capacity to contribute fiscally to MMCP activities are mixed. Many states and health plans that have used MMCP told us they would be willing to contribute to the costs of these activities but often indicated concern about their ability to do so. Related analyses considered on this issue show that there are many limitations to the ability of users to support these activities.

CONCLUSIONS

With RWJF's support for MMCP, CHCS staff have become a respected resource among states, health plans, and others who appreciate the role played by CHCS as a source of practical advice on operational insights into Medicaid managed care. We summarize below what we

conclude to be the most important functions that MMCP provides for these groups and where we perceive challenges or areas for improvement.

State Medicaid Agencies. MMCP's work with states appears particularly valuable in performing three functions: (1) communicating concepts and approaches that can help "move the field," (2) orienting new directors and program leaders to the key issues they will face and providing them with some tools for addressing those issues, and (3) working with individual states alone or in follow-up of group-based activity to help them implement initiatives and program features. MMCP's ability to convene Purchasing Institutes is an important "entry point" for assistance, although one-on-one contact with state leaders is essential in establishing relationships. CHCS' command of a wide array of materials, qualified staff and consultants, Web-based services, and other resources means that the Center has earned a reputation as a "go to" place for assistance with quality improvement.

From our perspective, at least three issues challenge MMCP's success in working with states and health plans to achieve the goals set out for the program by RWJF. First, in a field where leaders turn over rapidly, CHCS staff need to work continually to build and maintain relationships with key state leaders; such an effort takes staff time and effort. Second, with support based on reputation, CHCS needs to retain its reputation for qualified staff and consultants expert in the areas they address. Third, in a climate that seeks "instant solutions" and "magic bullets," CHCS needs to determine how best to focus its work so that innovations are both acceptable and realistic. The current environment will not support many cost-increasing strategies, yet the number of cost-saving innovations that lend themselves to rapid introduction are limited. Helping states negotiate the current environment is potentially the most important way that CHCS can support state activity.

Health Plans. The evaluation's findings indicate that MMCP's work with health plans has been particularly valuable in (1) working with plans to expand the use of targeted quality improvement initiatives within their system and (2) providing a point of support to Medicaid-dominant or similar plans whose needs are not well served by traditional associations and quality improvement organizations. MMCP's health plan–related activities leveraged intensive work in areas with a few plans (workgroups) to build knowledge more broadly (workshops, Quality Summit, toolkits), but the resultant change varied with the intensity of activity. Those plans involved with MMCP in several BCAP-related activities said that the activities have changed both how they think and how they practice. They also reported that they applied the framework developed to support BCAP across a variety of areas of quality improvement.

The main weakness to date in the BCAPs studied in the evaluation relate to their ability to generate relevant measures of process and outcome with which to gauge BCAP success in generating improvements in care. Observers who are active in commercial quality improvement activities noted that such measurement challenges are not unique to Medicaid and reflect the early learning process associated with the institutionalization of continuous quality improvement. MMCP also could be clearer on how it sets priority topics for BCAPs and whether the same outcomes are sought in areas with either weak or more clearly specified evidence and measures.

Consumer Groups. MMCP has not devoted many resources to the third core audience. Yet, without appropriate consumer engagement, many quality initiatives are doomed to fail. At a minimum, it would seem that an important consideration in MMCP's work with states and health

plans relates to helping them make sure that systems work for consumers. Consumers should not be listed as a core audience of MMCP unless the program intends to devote substantially more resources to that audience.

More broadly, it is important to credit MMCP with allowing CHCS to evolve into an organization that states, health plans, and many other groups rely on for assistance and an organization that has attracted other funders interested in related work. Core audiences do not distinguish MMCP from CHCS itself, suggesting that the organization that MMCP helped build is one that has created synergies across diverse programs and funding sources. Such capacity is likely to be important in supporting efforts to improve Medicaid care in the future as states and health plans struggle with how to respond to the fiscal and political environment in which they operate.

Recommendations for RWJF

The findings indicate that MMCP has become a relatively successful program that users view as a needed resource. They also indicate that without RWJF funding, or equivalent external support, MMCP's ability to continue its work is likely to be limited. MMCP is a resource-intensive program whose success requires extensive and continuing work with states and health plans if it is to generate program improvements. While users consider MMCP to be important and may be willing to contribute to the cost of program activities, states and health plans face both fiscal and administrative barriers in supporting the types of activities underwritten by MMCP.

While we cannot speak to the issue of relative priority vis-a-vis RWJF's other funding demands, MMCP currently benefits from the foundation's substantial historical investment; such investment would be lost or weakened if future funding were eliminated. Further, all indicators suggested that Medicaid will remain a critical focus for states in the years ahead and that managed care, in a variety of forms, will become a target of interest as states aim to enhance the value of purchases in a climate of increasingly tight resources. As discussed more in the report, MMCP also lends value in complementing other RWJF programs to help achieve foundation goals on quality and on racial and ethnic disparities.

If RWJF decides that it wants to renew MMCP, we suggest that CHCS and the foundation enter into a serious conversation about what RWJF seeks to gain with respect to MMCP and how it fits within the broader context of the Center. A business plan, developed by the Center, could serve as a point of departure for the discussion, allowing CHCS to articulate how it views RWJF (and MMCP) support and how it views other funding sources within the context of the overall organization.

Broader RWJF Programming

MMCP is one of an emerging new set of programs that depart from the traditional grant model to support organizations and people who, in turn, work with core audiences to develop targeted change. Our evaluation suggests that if RWJF decides to pursue models similar to MMCP, it can expect to face certain issues.

First, if new programs are developed in organizations without an existing infrastructure to support associated activities, RWJF should expect that such programs will require substantial time and resources to "find their legs." But RWJF also will gain more control over the final "image" of the organization and its goals and activities than if it tried to carry out the same activities in an existing organization with an established identity.

Second, endeavors organized around broad programming require organizations and staff who can secure and retain the support of their core audiences. That MMCP involved former Medicaid and health plan staff as key members of the program enhanced the credibility of the support provided by the Center such that users sensed that "they speak our language." The National Review Committee (renamed the National Advisory Committee) also contributed by including "names" known to core audiences, along with research experts experienced in working with state staff.

Third, programs such as MMCP require a long-term investment and are most useful when issues have "traction." Despite a managed care backlash elsewhere, managed care has remained a strong albeit evolving feature of the Medicaid program in most states, allowing organizational maturation and learning.

I. INTRODUCTION, CONTEXT, AND EVALUATION GOALS

The Robert Wood Johnson Foundation (RWJF) established the Medicaid Managed Care Program (MMCP) in 1995 with the goal of using Medicaid's shift to managed care to improve care for vulnerable populations served by the program. The national program office, the Center for Health Care Strategies (CHCS), was a new organization set up to run the program. Over time, MMCP evolved from a traditional grant program focused on chronically ill populations to a major program of technical assistance that aims to work with states, health plans, and consumers to encourage cutting-edge innovations. The newer, more targeted goal is to generate improvements in purchasing high-quality, "cost-effective" care through Medicaid managed care organizations that seek to generate quality improvements in clinical and administrative practices. To provide feedback on the outcomes of the program and their implications for future program funding, RWJF funded Mathematica Policy Research, Inc. (MPR) to conduct an evaluation of MMCP as it has operated since 2000. As context for the evaluation findings (the focus of the present report), the rest of this chapter reviews the objectives of the MPR evaluation, provides background on the impetus for MMCP, describes concurrent trends in Medicaid managed care as the program has developed, and details how MMCP has developed over time.

A. OVERVIEW OF EVALUATION OBJECTIVES

In expectation of MMCP's renewal in 2005, RWJF hired MPR to conduct a comprehensive evaluation of MMCP to support the foundation's decision making. While the timing of program renewal has been delayed until June 2007, the issues of interest remain the same. The evaluation is focused on MMCP as it has operated from 2000, covering mostly accomplishments based on activities in 2000-2003. In collaboration with RWJF, we identified nine questions as the key concerns of the evaluation:

1. What does MMCP aim to do, and how has the program evolved over its history?
2. Is MMCP 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 MMCP helped states become better purchasers, especially with respect to value-based purchasing? Are changes likely to endure?
4. Has MMCP helped health plans improve the care they provide in the areas that MMCP 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 MMCP's effectiveness? Does the leveraging of grants with technical assistance work better than awarding grants independently through solicitations?
7. Would MMCP users be willing to contribute to the costs of assistance provided by CHCS and under what conditions?
8. What does MMCP's experience imply about the value, importance, and expected accomplishments derived from future program funding? What are MMCP's strengths and weaknesses, and which areas deserve the most support?
9. What lessons can be drawn from MMCP experience about foundation grant making that involves a technical assistance component?

The above questions require an understanding of how MMCP's three constituencies—states, plans, and consumer organizations—view MMCP activities as well as an evaluation of whether states are in fact doing anything differently in purchasing managed care as a result of MMCP. The evaluation is not a formal "impact" evaluation because of limitations in establishing causality in a rigorous way, but it does examine the outcomes of changes inspired by MMCP.[1] The evaluation is designed to describe what activities and strategies MMCP has used to affect change (question 1), the degree to which core audiences know about MMCP and the nature of its reputation among those audiences (question 2), and whether actual changes have occurred and

[1] Limitations to such a formal assessment include the difficulty of identifying appropriate "control" states when MMCP was so broadly focused, the fact that states are so unique, and the evolving nature of outcomes sought.

persist (questions 3, 4, and 5).[2] We seek not only to answer the questions but also to understand the factors that promote or inhibit change.

Though answering the first five questions can provide evidence on the "value" provided by MMCP (question 8), RWJF's future funding decisions also mean that the foundation must ask other questions as it considers MMCP renewal, with the evaluation structured to provide information that can help guide RWJF in answering the above questions. As already noted, the use of MMCP funds for technical assistance is a relatively new use of RWJF program dollars such that the foundation seeks insight into the gains from a technical assistance strategy as opposed to traditional grant-making activities (question 6). Whether or not MMCP proves successful, RWJF will still need to decide whether funding such an effort is a priority. Therefore, information about alternative strategies to support MMCP is important in considering renewal (question 7). Finally, the evaluation seeks to go beyond MMCP to identify any general lessons from the evaluation for other RWJF programs and grant-giving activities (question 9).

The evaluation is designed to do more than just help RWJF make an "up-down" decision on program renewal. It is also intended to provide formative feedback to both RWJF and CHCS, the MMCP's national program office, on how the program is working and how it could be improved, including implications for related programming and initiatives. Though the present report focuses on the "big picture," the evaluation overview is complemented by a set of contributing reports that accompany the overview. These reports provide an in-depth look at particular sets of findings and grant outcomes. A list of the reports is included at the end of this document; readers with specific interests may find particular reports useful.

[2] Though the evaluation originally was slated to include a look at how these actions influenced overall access to and quality of care, we eliminated it because we intended to rely on information that CHCS said it would track to highlight its performance in this area. CHCS decided not to track such information, focusing instead on outcomes reported by those directly involved in CHCS initiatives. MPR's evaluation does, however, provide an overview of what is known about changes in access and quality of care as a result of Medicaid managed care over this period.

B. IMPETUS FOR THE MEDICAID MANAGED CARE PROGRAM

Medicaid is the main source of access to health care for a diverse sector of low-income people and vulnerable health care populations, addressing issues of long-standing concern to the Robert Wood Johnson Foundation. With total spending at $250 billion in 2002, Medicaid payments account for 17 percent of the nation's personal health care spending and half of nursing home costs (Kaiser Commission 2004). More than 50 million people are enrolled in the program, including 38 million low-income children and parents (Medicaid covers one in four children in the United States) and 12 million elderly and disabled individuals, half of whom are low-income Medicare beneficiaries (Kaiser Commission 2004). This last group makes up only 25 percent of those in the program, but they account for 70 percent of Medicaid spending.

Policymakers have long seen access and quality of care as major concerns within Medicaid. Medicaid beneficiaries often live in areas where few private physicians practice, and, even when physicians are available, they may be hesitant to participate in Medicaid because of low fees or other concerns (Gold et al. 2003; Zuckerman et al. 2004; Bindman et al. 2003). There is a long standing concern that Medicaid beneficiaries in some locales rely disproportionately on emergency rooms, hospital outpatient departments, and subsidized clinics and could lack a "medical home" or provider that can coordinate care (Medicaid Access Study Group 1994). Quality of care is a particularly salient issue for those with complex needs who require services spanning a diverse set of fragmented delivery systems (e.g., disabled or chronically ill individuals, institutionalized populations, mentally ill persons, individuals dealing with substance abuse) (Vladeck 2003; Frank, Golman, and Hogan 2003; Crowley and Allias 2003).

In the 1990s, states began to expand the use of managed care within Medicaid. Between 1991 and 1995, the share of Medicaid beneficiaries in managed care increased from 10 to 29 percent and, by 1998, over half (54 percent) of all Medicaid beneficiaries were enrolled in

managed care (see Figure I.1). Though the rate of growth in managed care began to slow, 43 states and the District of Columbia saw more than a quarter of their Medicaid population enrolled in managed care; 14 states counted more than 75 percent by 2000 (Kaiser Commission 2001).

While cost containment was a major motivation for introducing managed care, savvy states grew to recognize that a fundamental payoff could come in improved access to and quality of care within Medicaid (Chang et al. 2003; Gold and Mittler 2000). It was this environment that spawned MMCP; RWJF sought to capitalize on the growing focus on Medicaid managed care as a platform for improving access and quality of care for Medicaid beneficiaries, particularly those with chronic illness and disabilities.

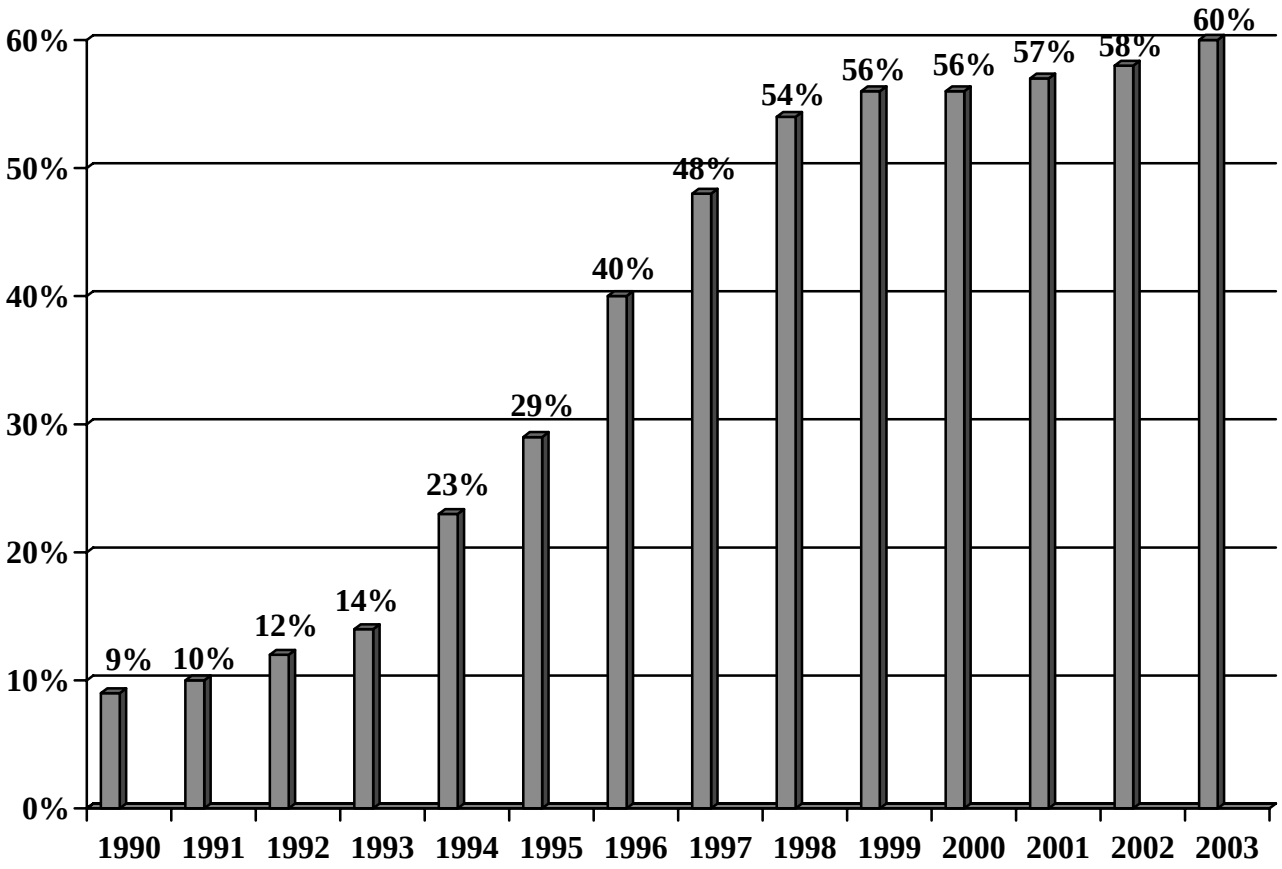
C. CONCURRENT ENVIRONMENTAL TRENDS

Since MMCP's inception, managed care has evolved in an environment that, in turn, has shaped MMCP. This environment had included state's continued reliance on Medicaid managed care despite the backlash in the commercial market, state by state variation that makes risk-based arrangements more appropriate in some states than others, an increasing trend toward relying on health plans dominated by Medicaid rather than commercial enrollees, the slower-than-expected growth of Medicaid managed care for disabled and elderly Medicaid enrollees, and change both in state fiscal environments and within RWJF itself.

Continued Relevance of Medicaid Managed Care. Readers need to recognize that, despite the overall backlash against managed care in the 1990s, such arrangements remain common today in many state Medicaid programs, particularly those in urban areas (Hurley and Somers 2003). The latest data indicate that 60 percent of all Medicaid beneficiaries were enrolled in managed care in 2003, 82 percent of them in full risk-based plans that the commercial

FIGURE I.1

PERCENTAGE OF MEDICAID ENROLLMENT IN MEDICAID MANAGED CARE 1990–2003



Source: Kaiser Family Foundation based on data from the Centers for Medicare and Medicaid Services (CMS).

sector tends to call health maintenance organizations (HMOs) (Kaiser State Facts on Line). The trend toward managed care in Medicaid stands in sharp contrast with both private insurance (which favors the more loosely structured preferred provider arrangement, or PPO) and Medicare (in which the vast majority of beneficiaries remain in traditional unmanaged fee-for-service arrangements).

State Variation. While states vary in their reliance on managed care (see Table I.1), 46 states and the District of Columbia had at least 25 percent of their Medicaid beneficiaries in

TABLE I.1

DISTRIBUTION OF STATES RANKED BY PERCENT MEDICAID MANAGED CARE ENROLLMENT AND TYPE, 2003

State by Arrangement	Managed Care			Traditional FFS
	All	Full Risk	Other	
United States	60%	49	11	40
At Least 25 Percent Full Risk				
Tennessee	100	100	0	0
Michigan	99	99	0	1
South Dakota	98	55	43	2
Colorado	95	77	18	5
Kentucky	92	71	21	8
Washington	91	91	0	9
Arizona	89	89	0	11
Iowa	89	72	17	11
Georgia	86	51	35	14
Utah	85	71	14	15
Delaware	80	80	0	20
Oregon	80	79	1	20
Pennsylvania	80	75	5	20
Hawaii	78	78	0	22
Nebraska	74	61	13	26
Connecticut	73	73	0	27
North Carolina	70	1	69	30
Indiana	69	34	35	31
Rhode Island	68	68	0	32
Maryland	67	67	0	33
New Jersey	67	67	0	33
Oklahoma	67	36	31	33
Florida	64	35	29	36
District of Columbia	64	64	0	36
New Mexico	64	64	0	36
Minnesota	63	63	0	37
Massachusetts	62	41	21	38
Kansas	57	25	32	43
New York	57	1	56	43
Nevada	53	53	0	47
Alabama	53	26	27	47
California	50	50	0	50
Wisconsin	48	48	0	52
Missouri	47	47	0	53
Texas	44	33	11	56
Ohio	41	41	0	59
South Carolina	29	29	0	71
All Other States				
Montana	70	0	70	30
Louisiana	77	0	77	23
Idaho	74	0	74	26
Arkansas	69	37	32	31
Vermont	65	0	65	35
North Dakota	63	1	62	37
Maine	60	0	60	40
West Virginia	50	16	44	50
Illinois	8	8	0	92
Alaska	0	0	0	100
Mississippi	0	0	0	100
New Hampshire	0	0	0	100
Wyoming	0	0	0	100

Source: MPR calculations from the Kaiser Family Foundation's State Health Facts, based on CMS data for December 2003.

managed care in 2002, with most having half or more in such arrangements. Further, full risk arrangements still remain very common in Medicaid managed care despite the fact that some plans have departed the program (Landon et al 2004). In 2003, 34 states enrolled at least 25 percent of Medicaid beneficiaries in risk-based arrangements and 9 had 75 percent or more enrolled in them. Some states (especially those with extensive rural areas) have found risk-based managed care arrangements unfavorable—45 states made some use of the arrangements in 1998 as compared with 39 in 2001 (Landon et al. 2004). The major alternative to full-risk arrangements are various forms of primary care case management (PCCM) models. These models dominate arrangements in states such as Idaho, Louisiana, Maine, Montana, North Carolina, North Dakota, and Vermont, but many states use the arrangements to complement their risk models. Recent analysis shows that states pursuing PCCM models have not yet used the quality measurement, feedback and improvement strategies that often are required of HMOs. MMCP has historically focused on risk-based arrangements because of the greater potential and sophistication of these arrangements, but some states pursuing PCCM models have participated in the program.

Trend toward Medicaid-Dominant Plans. In moving to Medicaid managed care, many proponents hoped that such arrangements would encourage participation by commercial plans and that the plans, in what has been referred to as "mainstream care," would bring with them access to the broader provider networks made available to individuals with private coverage. Despite some exceptions, the emergence of mainstream care has not materialized. While commercial plans continue to participate in the Medicaid program, the share of enrollees in "Medicaid-dominant plans," or plans with more than 75 percent of their enrollment from Medicaid or similar programs, has increased over time. In 2001, for example, 15 of the 39 states with risk-based managed care had either no or only one such plan, down from nine in 1998

(Landon et al. 2004). Even when commercial plans participate, their provider networks may not be the same as those offered by commercial products (Gold et al. 2003). Physicians may not be willing to participate in the Medicaid program, and the existing commercial network may not be well situated geographically for a Medicaid product. As a result, providers often are added to a commercial plan network when the plan participates in Medicaid. Some plans also want to offer access to traditional providers experienced in caring for the Medicaid population; in fact, some states require the availability of such providers.

Many Medicaid managed care plans have only limited involvement with mainstream quality improvement initiatives that have evolved mostly in response to the demands of large purchasers. A survey of plans in states with substantial managed care enrollment found, for example, that while 61 percent of responding commercial plans that participated in Medicaid received National Committee for Quality Assurance (NCQA) accreditation, only 12 percent of Medicaid-dominant plans were likewise accredited (Felt-Lisk and Gold 2003). MMCP's work with Medicaid managed care plans responds, at least in part, to the gap created by the relatively distinct evolution of many Medicaid managed care plans.

The Chronically Ill and Disabled in Managed Care. States engineered the shift to risk-based managed care by mandating that beneficiaries enroll in one of several available choices rather than employing entirely voluntary models of enrollment. Nonetheless, states typically have been reluctant to mandate such enrollment for those with extensive needs, such as the disabled, and some may even be concerned about voluntary enrollment models. Some states also grant exceptions for a particular population (e.g., children with special needs) or omit certain services (such as behavioral health) from risk-based arrangements. A recent study found that of 47 states with Medicaid managed care, all indicated that Temporary Assistance for Needy Families (TANF) eligible beneficiaries (generally children and their families) were eligible to

enroll but only 27 to 28 states said the same for disabled and elderly Medicaid beneficiaries (Table I.2). Further median enrollment levels are much lower for the disabled, particularly in states using full risk models. In addition, only a small minority of aged are so enrolled, a fact that also reflects the dual eligibility of the aged both for Medicare and Medicaid. The slower-than-projected growth of managed care arrangements for many of those with the most extensive needs was one important factor that led MMCP to move beyond its original focus on a grant-based program targeting the chronically ill.

State Fiscal Context. The state fiscal climate has changed since the mid-1990s and the launch of MMCP. For most of the period in which MMCP has operated, the state fiscal climate was robust, with Medicaid enrollments growing and publicly subsidized coverage expanded both through Medicaid and the State Child Health Insurance Program (SCHIP). However, state finances have eroded substantially in recent years, with some analysts estimating that state budget shortfalls will reach at least $70 billion in FY 2004 (Kaiser Commission August 2003). Medicaid is a major source of state spending, and the eroding fiscal position of states has strained state Medicaid programs. To the extent that fiscal pressures lead states to reduce growth in payment levels, cutbacks could make plans less willing to participate in Medicaid managed care. The immediate fiscal crisis also could make it harder for states to address long-term program improvements, including those identified by MMCP, or to generate their own financial support for improvement activities.

RWJF Leadership Change. The environment at RWJF also has changed since the launch of MMCP. From a period of rapid growth in grant awards, RWJF's grant-giving capacity, at least for the short run, is now considerably constrained. Both a declining stock market and the pressures of long-term program commitments limit the availability of funds for new programs. The change in environment has itself coincided with an expected change in RWJF

TABLE I.2

ENROLLMENT OF MEDICAID TANF, DISABLED AND AGED BENEFICIARIES IN MEDICAID MANAGED CARE BY TYPE OF STATE PROGRAM

		Eligible to Enroll			Median Percent Enrolled		
Type of Program	Number of States	TANF	Disabled	Aged	TANF	Disabled	Aged
HMO Only	22	22	12	9	77	26	6
HMO/PCCM	16						
HMO		16	10	7	42	32	15
PCCM		16	11	4	29	24	15
PCCM Only	9	9	5	2	80	48	6

Source: Schneider, Landon, Tobias, and Epstein (2003).

leadership as Risa Lavizzo-Mourey became RWJF's president, replacing Steven Schroeder. With the shift in leadership, one of the areas in which RWJF has begun to place more emphasis is clinical outcomes and quality of care, particularly for the chronically ill and racial and ethnic minorities (Lavizzo-Mourey 2003). The foundation also seeks to make targeted improvements within specific time frames. The renewal of MMCP will be subject to RWJF's evolving context.

D. OVERVIEW OF MMCP AND ITS EVOLUTION

Over its history, MMCP has evidenced considerable evolution (Table I.2; see White and Gold 2004 for a fuller description). Indeed, CHCS staff see MMCP's capacity to evolve as one of the program's essential features. We summarize here what we see as the major characteristics of the program since its inception (see Table I.3).

1. Program Launch and the Early Years (1995–1998)

RWJF launched MMCP in 1995 and lodged the program in a new entity—the Center for Health Care Strategies (CHCS), which was charged with operating the program and serving as a

TABLE I.3

HISTORY OF RWJF'S MEDICAID MANAGED CARE PROGRAM

Board of Trustees authorizes $5 million for a national program office for further development of the concept of an MMCP.	January 1995
Board of Trustees authorizes $15.9 million for five years, including $14 million for feasibility studies, analytic work, service demonstrations, and evaluations and $1.9 million for technical assistance and direction.	July 1995
CHCS awards its first model demonstration grants and best practices grants.	1996
CHCS awards its first planning grants for model demonstrations.	1997
CHCS receives delegated authority for directly authorizing grants up to $500,000.	November 1997
CHCS introduces "readiness assessment concept" into its work and begins to transition to a new strategy plan.	1997 to late 1998
Board of Trustees authorizes five-year renewal of funds up to $25 million, of which $13 million is for demonstration and evaluation grants, $5 million is for best practices grants, and $7 million is for a new series of technical assistance initiatives that include state Purchasing Institutes, best clinical and administrative practices (BCAP) workgroups, a Consumer Action agenda, and other activities.	October 1999
CHCS convenes first Purchasing Institute under MMCP.	March 2000
Board of Trustees approves one-year grant of $2.8 million for CHCS technical assistance and staff support.	April 2000
CHCS convenes first BCAP (on birth outcomes) under MMCP.	April 2000
MPR submits findings from its short-term assessment of MMCP.	April 2001
RWJF Board approves 13-month technical assistance and development grant for $3.3 million	July 2001
CHCS awards first set of Consumer Action grants.	Mid-2001
CHCS completes strategic planning aimed at creating synergy among core products. MMCP is reorganized around core organizing principles tied to target constituencies. Responsibilities for technical assistance, grants, and other activities are integrated around core constituencies.	January 2002
RWJF renews MMCP and authorizes $10 million in additional funding for the next three years (with carryover of $20 million from funds unspent from previous grants).	July 2002
RWJF awards MPR a contract to evaluate MMCP in anticipation of 2005 renewal.	August 2002
CHCS targets its model demonstration grants, soliciting applications involving managed care for children with special needs, coordination of managed behavioral and general health care, and managed long-term care.	2002
CHCS implements a new grant-making strategy of actively soliciting model demonstration grant proposals from states and plans that participate in technical assistance activities (e.g., Purchasing Institute, BCAP).	2003
CHCS begins more actively to explore options for other sources of revenue.	2003
RWJF and CHCS decide to delay reauthorization of program until June 2007 on a no-cost basis by reallocating grant funds to technical assistance.	2004

national program office. Former RWJF senior staff member Stephen Somers managed the Center and program, which at that time were virtually one and the same. At the start, the Center was mainly a grant-making organization, issuing calls for proposals and providing grants to support innovation (Fasciano and Angeles 2003; White and Gold 2004). The program supported two major types of grants:

- ***Model Demonstration Grants***. The grants provide up to $500,000 (increased to $750,000 in 2002) over a three-year period to support the development of new models for managing care for special needs populations. Typically awarded to states and health plans, the grants are intended to support demonstrations. In 1997, MMCP awarded initial planning grants of up to $100,000 to provide support for grantees either to explore the feasibility of their proposed demonstration or to refine their plans before the Center decides whether to award a full demonstration.

  Best Practice/Policy Study Grants. The grants provide up to $100,000 to state agencies, health plans, consumer organizations, health services researchers, and policy analysts to identify, develop, or test operationally relevant innovative practices that address one or more of the program's five policy aims.[3]

Center staff screened the proposals, but decisions on awards were the province of a National Review Committee (NRC), an RWJF-/CHCS-appointed group of Medicaid managed care experts with a stable membership over many years.

By 1997, CHCS staff voiced concern that MMCP's grant-giving strategy was not as effective as desired. In particular, the staff noted that the traditional grant-making process was too passive in that it relied on the strength of applicants and generated proposals that often proved to be weak. Over the next few years, center staff began more actively to engage with the

[3] These aims included (1) improving access to a usual source of care and appropriate specialty services; (2) increasing the use of effective preventive care services; (3) preventing unnecessary hospitalizations and institutionalizations; (4) promoting clinical quality by using accepted standards of care; and (5) building organizational capacity to improve managed care services (White and Gold 2004). Never very dominant in the program's thinking, they have been de-emphasized in favor of more targeted measurements tied to specific activities (e.g. BCAP).

states by focusing on assessing their "readiness" for managed care and providing targeted technical assistance.

Concurrently (in late 1998), RWJF completed an internal assessment of MMCP and concluded that, while the program had produced useful products and had earned respect as a neutral convener, Medicaid managed care had progressed less rapidly than envisioned (particularly for the most vulnerable Medicaid beneficiaries). The assessment also noted that MMCP could be strengthened with a more clearly defined and more effectively communicated and executed strategy.

2. Building the Field: Transition to Technical Assistance Support (1999–2001)

With MMCP's grant renewal in the offing, CHCS began to recast the program's strategy in response to both internal and external assessments. It defined three core audiences for the program: states, plans, and consumers, with initiatives developed to advance each audience's health care agenda in accordance with four core organizing principles:

- ***Informed Purchasing.*** To promote the purchasing of high-quality and cost-effective managed care services by states
- ***Managed Care Best Practices.*** To support quality improvements in clinical and administrative practices in managed care offered by participating health plans
- ***Consumer Action.*** To promote the ability of consumers to navigate health care delivery systems and to institutionalize a consumer role in the design, implementation, and monitoring of publicly financed managed care
- ***Integrated Systems of Care.*** To promote the integration of services and funding across public agencies, managed care organizations, and providers

In 1999, CHCS received a five-year award of $7 million from RWJF (in addition to $18 million in additional funds for grants) to support a set of technical assistance activities to promote the above principles. These funds were used mainly to support development of

initiatives built around its core audiences, namely the Purchasing Institute, the Best Clinical and Administrative Practices initiative, and the Consumer Action agenda.

- ***Purchasing Institutes*** aim to help Medicaid staff improve their purchasing skills through two- to three-day seminars that are attended by teams of senior staff from multiple states that are intended to go back home and continue work over the course of a year to generate targeted improvements.
- The ***BCAP*** initiative aims to enhance the ability of Medicaid health plans to provide quality care within budgetary limits through a rapid-cycle improvement process. BCAP workgroups involve 10-12 health plans getting together three to four times over nine to 12 months as they work on improvements in a given clinical or administrative area (e.g., asthma, care for adults with chronic illness and disability), followed by telephonic and other support later. The lessons from these groups are fed back to health plans more generally in a variety of forms, including meetings and toolkits.
- The ***Consumer Action*** agenda aims to help consumers navigate and establish a formal role in publicly financed managed care systems. The primary vehicle for advancing the Consumer Action agenda has been seed grants that are awarded to consumers and family–based organizations.

CHCS also used MMCP funds to convene periodic meetings of a Managed Care Pricing Forum (subsequently renamed the Managed Care Solutions Forum) to bring together stakeholders from all sectors to discuss emerging issues, identify needed analysis and provide feedback on reports, proposals and priorities for policy attention.[4] CHCS also began to redesign its Web site and to pay more attention to the structure of the way in which it commissioned and released reports funded through grants of diverse types. The intent was to target content by user group.

Anticipating decisions on additional funding to support such technical assistance in 2001,[5] RWJF asked MPR to conduct a short-term assessment of MMCP's new direction and potential.

[4] A "stakeholder project" working with the Health Care Financing Administration (HCFA) and others to gain consensus on special needs populations ($0.5 million) was funded but disbanded in 2000 when gaining consensus proved difficult. The remaining funds were spent on BCAP.

[5]MMCP's funding historically separated funds for grants from funds for CHCS' own staff. In 2000, RWJF gave CHCS a one-year grant of $2.8 million to support staff technical assistance and development activity,

In response, MPR reviewed documents and conducted interviews to trace the history of and early experience with each of the four organizing principles and to evaluate general publication and dissemination efforts (see Gold and Mittler 2001).

The MPR assessment concluded that, among major constituencies, public purchasers experienced in working with MMCP were particularly interested in new initiatives. All constituencies viewed MMCP (which users saw as identical with CHCS, the organization funded to operate the program) as providing an important and unique product not otherwise available. Constituents particularly liked the interactive forums, the emphasis on operations, the focus on substantive matters, and the small scale of activities. But the authors suggested that CHCS could improve MMCP's effectiveness by developing a more integrated vision of how the program's components related to one another and identifying critical synergies. Further thought on how grants related to hands-on work and how general technical assistance (TA) related to TA associated with workshops and other initiatives were issues that likewise demanded consideration. The report noted that it was too soon to determine whether MMCP interventions led to change.

3. The Thrust of Activity since 2001

Building on the MPR assessment, RWJF renewed MMCP for an additional three years in 2001, effective July 2002, and authorized $10 million in new funds to complement the funds remaining from previous grants (about $20 million). With the renewal, CHCS continued to develop its new focus on technical assistance around what it saw as its three main constituencies—states, health plans, and consumer groups. The program's work was

(continued)
anticipating further funding in 2001. In 2001, an additional $3.3 million was awarded for a similar purpose. In 2002, all funding for MMCP was consolidated into a single grant.

restructured around three of the four organizing principles that corresponded to each of these constituencies: informed purchasing, managed care best practices, and Consumer Action. CHCS dropped the fourth goal, integrated systems of care, as a separate focus because it was embodied in the three other goals.

Rather than viewing core functions as independent entities, MMCP now view grants, technical assistance, and publications as related ways of working with key audiences to achieve desired goals. Accordingly, model demonstration and planning grants are increasingly targeted to participants in Purchasing Institutes (states) and the Best Clinical and Administrative Practice (BCAP) workgroups that focus on quality improvement (health plans). Instead of general solicitations, MMCP also moved toward targeted solicitations that include work with children with special needs, managed behavioral and general health care coordination, and managed long-term care. Rather than assigning staff members to either grant-making or technical assistance activities, the program has assigned personnel to each of the core MMCP audiences.

In addition, MMCP's work over time moved increasingly toward a focus on improved quality and health care outcomes—whether through informed purchasing in states or quality improvement in health plans. While capitation rate setting was the focus of some early work, MMCP de-emphasized such work, as illustrated by changing the name of the Pricing Forum to the Solutions Forum. The latter is now a structure to be used on an ad hoc basis to address emerging issues, such as pharmacy benefits. In addition, CHCS has placed more stock in the performance measurement of its MMCP activities. CHCS refined the measurement strategy for BCAP initiatives and grant making and has started to develop similar processes for Purchasing Institutes. CHCS also has sought to adapt MMCP's work to respond to current issues. For example, MMCP now partially supports a Business Case for Quality initiative that is providing small grants to support quality improvement initiatives that sponsors and others believe can

generate a return on investment. (The Commonwealth Foundation is supporting an evaluation of quality-related savings from the initiative). With support from MMCP and other RWJF funds, CHCS also is convening a BCAP that will focus on racial and ethnic disparities.

CHCS also has introduced changes in MMCP in response to the changing fiscal environment. Because it had funds on hand and recognized RWJF's financial pressures, CHCS worked with RWJF staff to negotiate a no-cost program extension that delayed renewal by an additional 24 months until June 2007. Since approval of the extension, MMCP has continued to shift away from grant making and toward technical assistance and direct work with stakeholders. In fact, MMCP plans to limit its grant giving to highly targeted awards that advance its agenda; the awards will offer small sums and assume substantial grantee investment supported by MMCP technical assistance. At the last Quality Summit, for example, attendees were given the opportunity to compete for small "innovation" grants intended to encourage change and convert the prestige of being selected as a grantee into substantial plan investments. Funding limitations also underscore MMCP's limited focus on Consumer Action. Center staff said that they were concerned that the payoff from Consumer Action grants was low; as a result, the Center has stopped funding Consumer Action activities—at least temporarily. Staff are reassessing strategies for effectively reaching consumers as well as MMCP's relative strength in Consumer Action.

CHCS has increasingly sought to diversify its funding base (see Table I.4). With a total award since inception of $62 million, MMCP continues to be the dominant source of funds, but CHCS has been increasing the RWJF support it gets for other programs. CHCS also now receives support for targeted activities from the California Health Care Foundation (CHCF), The Commonwealth Fund, The Annie E. Casey Foundation, The David and Lucile Packard Foundation, the Agency for Healthcare Research and Quality and others.

TABLE I.4

PRELIMINARY SUMMARY OF CHCS FUNDING BY SOURCE AND YEAR OF COMMITMENT, 1995-2004 ($ IN THOUSANDS)

	RWJF-MMCP	RWJF-Other	Casey	CHCF	CMWF	Packard	Other
Total	$62,000	$8,188	$2,327[b]	$1,061	$509	$157	$1,480
1995	20,950	1,700	0	0	0	0	0
1996	0	0	0	0	0	0	0
1997	0	0	250	0	0	0	0
1998	0	0	575	0	0	0	0
1999	25,000	1,896	325	0	0	0	0
2000	2,835	300	0	20	0	0	0
2001	3,254	1,950	43	130	0	117	40
2002	10,000[a]	483	0	430	265	0	804[c]
2003	0	898	635	0	10	0	200
2004	0	962	500	481	234	40	436

Source: Preliminary Information Provided by CHCS. Reflects funding by commitment year, not the funds available or programmed for activity in that year.

[a]In 2002 the remaining funding from previous grants (about $20 million) was consolidated into a single grant with the new funding
[b]Of the $2.32 million, $2.15 million was for the Children in Managed Care program
[c]Of the $0.8 million, $0.6 million is related to substance abuse technical assistance

To a considerable extent, CHCS' ability to attract such funding reflects the products and expertise developed under MMCP. That is, MMCP has allowed CHCS to create a platform that can offer similar or related services to other funders. While we have not conducted a fiscal analysis, MMCP's contribution to building CHCS has had, and likely will continue to have, an important enabling influence on this activity.

CHCS also has been able to use funding in related programs to test out modifications in its strategies that may ultimately be employed in MMCP. For example, CHCS has received funding from both The Commonwealth Fund and CHCF to employ the BCAP model to more geographically focused efforts at change—terming this a BCAP Collaborative. Further, in contrast to current work that reaches out to constituent groups separately, these CHCS initiatives

will be structured to bring together constituencies such as states, health plans, and consumers to achieve change. These fundamental changes in the BCAP model assume that competing plans in the same geographic areas can collaborate on quality improvement and that the field has sufficiently advanced so that diverse participants can forge relationships to work together on projects. In the coming years, CHCS also hopes to incorporate providers into the mix, although current experience is limited.

4. Key Points of Note

MMCP has a number of important features that readers should keep in mind in thinking about our evaluation and what it has found. We highlight them briefly here to reinforce their importance.

A dynamic program. CHCS views MMCP as a dynamic program that evolves as it learns and as its environmental circumstances change. Center leadership believes that such dynamism is a core part of the program, enabling it to stay on the cutting edge and to foster innovation in a changing marketplace. Because such changes have evolved rather than been abrupt, there is much to learn from the past about what to expect in the future. Extrapolating is particularly relevant since the transition around 1999 to a more hands-on approach in working with core audiences.

Highly leveraged with related CHCS activity. For much of its history, MMCP virtually *was* CHCS. MMCP provided the funding that allowed the Center to form and the resources to let it grow. Some of this growth involves taking on new kinds of responsibilities but much of it supports expansion of work highly related to that of MMCP. While RWJF may perceive MMCP to be a distinct program, neither the Center nor its core audiences make these distinctions. Thus, a critical element of what MMCP has done has been to establish the credibility of CHCS for certain types of work. While our evaluation focuses on MMCP, it is impossible to fully separate

the program from the Center it has spawned and doing so would remove an important aspect of MMCP's potential accomplishments and the way it integrates into CHCS' work.

A broad definition of technical assistance. The technical assistance that is promoted in MMCP involves a variety of types of help, much of it clearly different from the kinds of one-on-one on-site support to single organizations that comes to mind as the traditional technical assistance model. CHCS views Purchasing Institutes, BCAP workgroups, and a variety of other group-based work as a core part of the technical assistance offered. Indeed, much of MMCP's current work now builds on these activities to identify organizations with whom to work more closely and to identify changes to support. Such support can come from one-on-one site visits, availability of telephonic consultation, grant support (typically in small amounts), written materials including toolkits and resource material, and peer communications through listservs and other similar Web-based tools. In MMCP, CHCS aims to use combinations of such support to encourage change.

II. FRAMEWORK AND APPROACH

A. FRAMEWORK FOR ASSESSMENT

Figure II.1 summarizes the framework that we developed to support the evaluation. It shows that RWJF funds CHCS on behalf of MMCP so that CHCS can hire staff, make grants, and take advantage of outside experts to formulate a series of programs and activities.[6] MMCP directs its activities to three core audiences and targets specific goals: states (informed purchasing), plans (managed care best practices), and consumers (Consumer Action grants help consumers to navigate and participate in the health care system). (See Figure II.2 for additional detail on these activities.) MMCP aims to expand audiences' knowledge by improving and strengthening state purchasing and health plan practices. If practices change, MMCP hopes ultimately to improve care and outcomes, though long-term effects on quality, cost, and other outcomes will depend on several factors, some of which MMCP cannot control.[7]

MMCP exercises greatest control over both the strategies it uses to intervene with core audiences and the manner in which it applies those strategies. It has least control over the external environment in which its core audiences operate. Currently, for example, states are experiencing substantial fiscal stress; as a result, state programs will have to respond in ways that increase the interest in diverse forms of managed care while limiting the resources available to support it and its efforts to enhance quality of care. Staff turnover, both at the state level and

[6] Originally, MMCP and CHCS were virtually one and the same, with MMCP the only CHCS program aside from a $1.7 million consumer grant from RWJF for Building Health Systems. Though CHCS now has other sources of revenue, MMCP still is the dominant program that makes an important contribution to CHCS' overhead. Other programs, however, can also have a synergistic effect on MMCP activities to the extent they share common goals.

[7] CHCS defined the outcomes as measured by an increase in access to care, increase in the use of preventive services, reduction in unnecessary hospitalizations and institutionalization as defined by improvements in clinical quality based on accepted standards of care, and building organizational capacity to improve managed care services.

FIGURE II.1

FRAMEWORK FOR EVALUATING MMCP

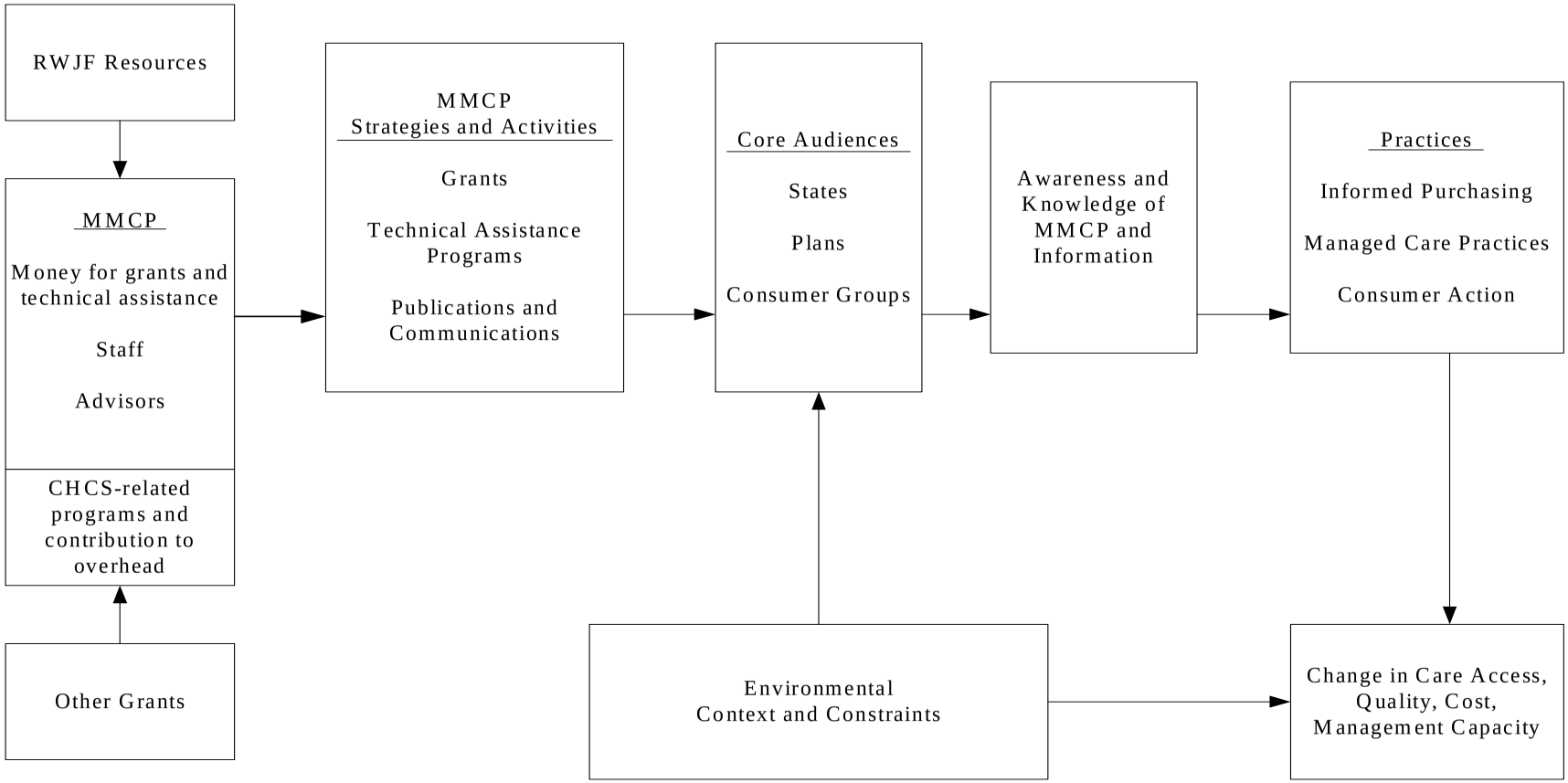
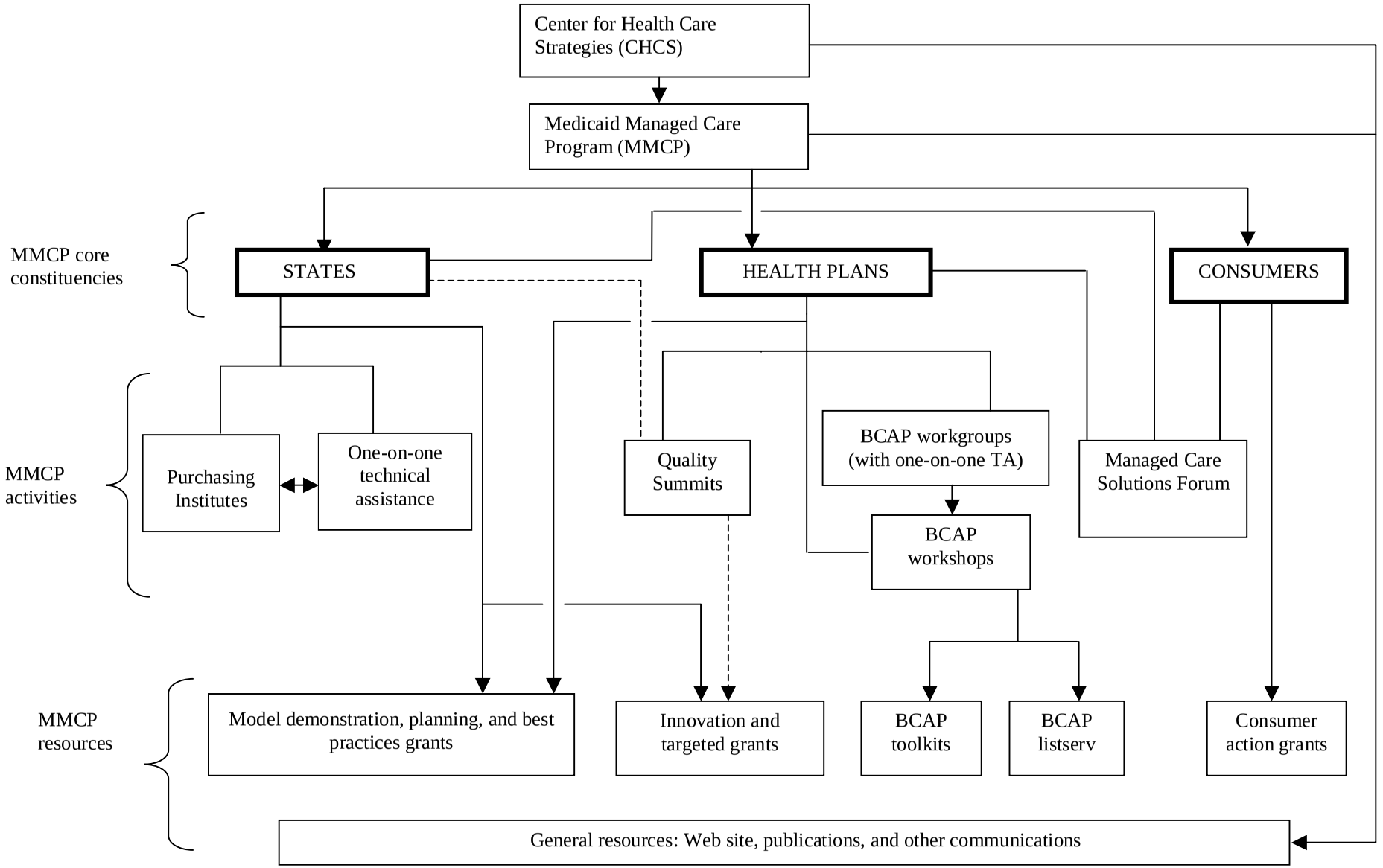


FIGURE II.2.

MAJOR MMCP PROGRAMS AND ACTIVITIES



within plans, is another barrier to both program stability and the sustainability of change in practices. At the same time, insufficient organizational infrastructure and competing priorities undermine the power of consumers.

B. STRATEGY AND DATA SOURCES FOR ASSESSMENT

MPR's strategy for assessing MMCP follows a two-pronged approach; it combines a broad-brush view of how MMCP is perceived by its core audiences with an in-depth look at outcomes for the constituencies with which MMCP has worked most closely. The latter would be expected to show the most immediate direct outcomes. We relied on four core data sources described in detail in the supporting reports but summarized below.

Program Staff Interviews, Documents, Observations. We remained in close contact with the foundation and program office over the course of the evaluation. Through a mix of interviews and a review of written materials, we documented the history of the program and its evolution. We also attended some of the meetings sponsored by MMCP in order to develop "on the ground" perspective on how activities functioned in practice.

Surveys of MMCP's Core Audiences. We conducted structured interviews with a census of MMCP's core audiences, developing sample frames to support the study when such did not exist. The survey included telephone interviews with each state Medicaid director and a separate but related mail survey with telephone follow-up of key senior staff involved with managed care in each state Medicaid program. We conducted two other mail surveys with telephone follow-up, one with all participating Medicaid health plans nationwide and another with a set of organizations that we identified as involved nationally or regionally in consumer advocacy. We also conducted a brief survey that included other stakeholders who were not part of the core audience groups but who could shed light on the potential value of MMCP. Respondents included policy analysts in organizations concerned with Medicaid managed care, staff of the

Centers for Medicare & Medicaid Services (CMS) in central and regional offices who were responsible for Medicaid managed care, and researchers active in Medicaid managed care. Though survey instruments varied across the audiences, they generally covered the following topics:

- General awareness and assessment of CHCS and MMCP
- Participation and assessment of key relevant programs
- Awareness and use of publications, monthly newsletters
- Use of grants and technical assistance
- Perspectives on MMCP versus other sources of operational support and willingness to pay for assistance
- Implications of audience leadership/organizational stability on effectiveness
- Perceived strengths and weaknesses of MMCP, areas for improvement
- Background of interviewee

States were surveyed between April and June 2003 and health plans and other groups between September and December 2003. The response rates to the surveys were high, with 85 percent or more of each group responding (see Table II.1).

In-Depth Interviews with Participants in MMCP Activities. To provide evidence on outcomes, we conducted in-depth interviews with key participants in various workgroup activities and analyzed the outcomes associated with particular types of activities. In each case, a core member of the MPR staff associated with the evaluation conducted the interview in accordance with a semi-structured protocol. Following each interview, MPR staff wrote detailed notes of the responses in support of the analysis. The diversity of MMCP activity required interviews with representatives of several types of groups.

Given that states are small in number but have been MMCP's core audience since program inception, we interviewed each state director, as noted above. The calls combined closed-ended

TABLE II.1

SUMMARY OF SURVEYS' TARGET AUDIENCE, MODE, SAMPLE SIZES, AND RESPONSE RATES

Survey Name	Target Audience	Time Period	Mode	Number of Eligibles in Survey	Respondents	Response Rate (percent)
State Directors	All states except Alaska and Wyoming (no managed care); if director began after November 2002, interview former director	June–September 2003	Telephone interview using a combination of closed- and open-ended items. Senior researchers on the project conducted the interviews.	49	43, including 26 current directors, 12 former directors, 4 current deputy directors, and 1 former deputy	88
New State Directors	States with a new Medicaid director after November 2002*	July–August 2004	Same as above.	14	13	__
Senior State Staff	States identified up to 7 senior staff respondents for Medicaid managed care, including those involved in contracting, rate setting, quality, and other major functions (e.g., planning, data management)	April–June 2003	Mostly closed-ended mail survey with telephone follow-up (45 percent completed the survey by telephone).	171 (from 49 states	160 (from 44 states)	94
Medicaid Health Plans	Risk-based health plans participating in Medicaid managed care (excludes Primary care case management and other non-risk models.)	October–December 2003	Mostly closed-ended mail survey with telephone follow-up (54 percent telephone alone).	224	192	86
National Audience	List frames of consumer and other groups as described below	November–December 2003	Mostly closed-ended mail survey with telephone follow-up (43 percent responded solely by telephone).	94	89	95
Consumer Groups	Diverse types of major national and regional groups			20	17	85
CMS Staff	Central office staff and lead regional staff with Medicaid managed care responsibility			21	20	95
Medicaid Policy Analysts	Staff in congressional agencies, foundations, associations, and others with an interest in Medicaid managed care			37	36	97
Medicaid Applied Researchers	Applied researchers in universities and research and consulting firms who publish in Medicaid managed care			16	16	100

* Includes one state whose director had been in place. She had no knowledge of MMCP in 2003 but was planning to attend a Purchasing Institute after our first interview.

questions (for potential use with the other surveys) with open-ended items that sought more detail on a variety of topics, including whether the programs had made concrete changes in response to MMCP. To ensure knowledgeable responses, we aimed to interview former directors if the existing director had not been in the position since at least November 2002. In states that experienced turnover, we conducted a follow-up round of more open-ended interviews with new directors in summer 2004. These latter interviews allowed for an update of state activity and helped address the issue of the stability of changes given inevitable staff turnover. Our analysis of state outcomes (1) reviewed the available information from the surveys of state personnel to identify those states that reported concrete changes to their program, (2) synthesized what we knew about these changes from the information already available to us, and, in a few cases, (3) followed up with additional calls to states to assess their changes. Available information included detailed interviews with grantees (as noted below), including states that received larger grants.

Among health plans, BCAP is the most prominent and intensive MMCP initiative. Modeled along the lines of the Institute for Healthcare Improvement's Breakthrough Series, the workgroups meet three to four times over nine to 12 months in an initial phase of intensive work followed by a less intense period of telephone follow-up. We developed case studies of the first three BCAPs in the program and of the most recently completed one (BCAP 5). Each case study involved in-depth telephone interviews with two members of each plan that participated in the workgroups and a review of associated documents and reports. We also attended some of the workgroup sessions or follow-up activities. We scheduled interviews well after the workgroups met to allow us to gather evidence on the sustainability of the activities and their short-term effects.

For consumer groups, Consumer Action grants are the main source of assistance. We reviewed grant applications and reports produced under each grant and conducted telephone interviews with recipients of the grants in each of the two funding cycles.[8]

To elicit more insight into MMCP grant function in general, we also interviewed and reviewed documents for a stratified sample of those receiving diverse types of grants. Grantees were eligible for interview if MMCP awarded the grants after January 2000 and the project was either complete or, in the case of multiyear grants, almost complete as of fall 2003. Grants of less than $25,000 were excluded, as were Consumer Action grants, which are addressed in a separate analysis as described previously. The 30 grants selected for the subanalysis included all 10 eligible model demonstration grants (the largest grants), a sample of 18 best practices/policy studies grantees stratified to ensure inclusion of diverse grantees (health plans, consumer groups, research organizations, providers, and state agencies), and two community integration grants.[9]

Other Targeted Analyses. We complemented information from the previous sources with a select number of additional analyses that addressed important gaps.

First, to develop a firm estimate of "reach," we created a spreadsheet for both states and plans to show the activities in which states/plans participated and the geographic "match" activity across states/plans.

Second, to develop a better measure of "state sophistication," we negotiated access to data collected by Harvard researchers from a 2002 survey of states on their Medicaid managed care

[8] This set included 19 grantees, excluding the 10 grantees that received grants associated with the RWJF Covering Kids and Families Initiative. The latter were excluded here because the types of activities covered by the grants were already undergoing evaluation.

[9] MMCP awarded seven one-time-only grants between 2001 and 2002 in response to the U.S. Supreme Court's *Olmstead* decision in 1999. States used the grants to develop action plans to provide "medically appropriate community-integrated care" to certain eligible populations, as required by the *Olmstead* decision.

purchasing practices.[10] While individual state identities cannot be disclosed, the data allowed us to develop a measure of state sophistication in purchasing for use in better identifying the characteristics of states reached by MMCP. Given that the Harvard surveys have been conducted over time, the publicly reported data on results also give an indication of longitudinal changes in Medicaid managed care activity and sophistication. We use the survey results to provide context for the evaluation.

Third, we used related funds available for an evaluation of the National Health Care Purchasing Institute (NHCPI) to provide additional insight into the ability of federal and state purchasers to support technical assistance and the potential trade-offs in different financing models for TA services. We focused on Medicare, a priority of NHCPI, and Medicaid, a priority of MMCP. To develop the analysis, we subcontracted with a consultant, Ruth Martin, to conduct analyses and prepare reports on two related topics. The first, based on interviews with CMS and state staff, provided insight into how these major payers viewed their needs for expert panel convening and technical assistance and their ability to purchase such services. The second developed three grant-making models RWJF might consider for TA services and gathered insight into their strengths and weaknesses.

C. METHODS OF ANALYSIS

Table II.2 shows the sources of information relevant to evaluation questions one through seven; we will use the answers to those questions to address the final two evaluation questions relevant to overall accomplishments, lessons and conclusions. Given the wealth of information collected, we first conducted separate analyses for distinct parts of the work. The major contributing reports were developed to support the present overview report and are included as

[10] The Robert Wood Johnson Foundation also funded this survey. A paper with findings and longitudinal trends was recently published (Landon et al. 2004).

TABLE II.2

EVALUATION QUESTIONS AND SOURCES OF INFORMATION

Evaluation Question[a]	Program Staff, Documents, Observing Meetings	Interviews with Participants in Activities	Surveys of Core Audiences and Others	Other Targeted Analysis
1. What does MMCP aim to do, and how has the program evolved over its history?	Interviews with CHCS staff, review of CHCS and foundation documents			
2. Is MMCP regarded as a valuable resource by its key audiences—sates, plans, and consumer organizations—and what is its general reputation among key stakeholders?			Interviews with all state directors; survey of senior staff, survey of health plans, survey of consumer groups and national audiences	"Reach" of activities—which states and plans participate in what
3. Has MMCP helped states become better purchasers, especially with respect to value-based purchasing? Are changes likely to endure?		Interviews with program directors on specific changes, role of stability, and barriers to change	Reports of actual changes in response to MMCP	Analysis of Howard survey of state Medicaid agencies on trends and analysis of sophistication
4. Has MMCP helped health plans improve the care they provide in the areas that MMCP targets? Are changes likely to endure?		Case studies of BCAPs 1–3, 5	Reports of use after BCAP related participation in events	
5. Have consumer grants been effective in accomplishing the consumer action agenda? What are the accomplishments?		Interviews with recipients of Consumer Action grants (Covering Kids and Families grants excluded)	Responses from consumer groups in general survey	
6. What has been the respective contribution of grants and direct technical assistance to MMCP's effectiveness? Is the leveraging of grants with technical assistance work preferable to awarding grants independently through solicitations?	Review of grant-making history, nature of grants	Targeted follow-up analysis of a sample of different types of grantees	Awareness and perceived value of grants	
7. Would MMCP users be willing to contribute to the costs of assistance provided by CHCS and under what conditions?			Reports of state plans' ability/willingness in interviews	Review of separately contracted reports on federal and state technical assistance needs, strategies, and ability to pay for help needed for Medicare and Medicare.

[a]The final two questions will be addressed by an analysis of the findings generated from these seven questions.

supplements. A list and description of such supplements is included as an appendix at the end of this report. In sum, the major contributing reports are:[11]

- A final program synthesis that incorporates early summaries of program activities involving both technical assistance and grants (White and Gold 2004, building on Gold and Mittler 2001; Angeles and Gold 2002; Fasciano and Angeles 2002).
- A comprehensive review of the survey findings for each key group, including (1) states (Draper and Gold 2004), (2) health plans (Taylor and Gold 2004), and (3) consumer groups and the national audience (Krissik and Gold 2004). The analysis in the reports uses basic descriptive analysis techniques.
- Individual reports on each of the targeted in-depth analyses, including (1) case studies of each of the four BCAPs that were subject to study (Mittler et al. 2004), (2) an analysis of the Consumer Action agenda based on the survey and grantee interviews (McHugh 2004), and (3) an analysis of the experience with grants and the results of the grantee interviews (Taylor and Gold 2004). We also developed two appendices for the state report that provided (1) a systematic review of the concrete changes identified by states as a result of their participation in MMCP (Krissik and Au 2004) and (2) findings from follow-up interviews of new state Medicaid directors (Howell and White 2004).

Contributing reports provide a detailed review of the individual methods underlying each form of analysis. For this overview report, we sought to draw together and elaborate on the overall findings of each supporting analysis with a focus on each analysis' relevance to the individual evaluation questions guiding the evaluation.

D. ORGANIZATION OF THE REMAINDER OF THE OVERVIEW REPORT

Chapters III to VI summarize the main findings generated from the evaluation. The questions include:

- Is MMCP a valued resource by core audiences and other stakeholder (Chapter III)?

[11] We also used separately contracted analytical papers by Ruth Martin Consulting. The first describes how federal and state governments involved in Medicare and Medicaid perceive their needs for technical assistance, the processes they use to procure such support and any embedded constraints, and what this implies about priorities and needs for support. The second reviews alternative grant-making models RWJF might consider for outside funding to support such activities (Martin and Kenneson 2004a, b).

- Has MMCP helped states become better purchasers, and are changes likely to endure (Chapter IV)?
- Has MMCP helped plans improve quality of care in targeted areas, and will changes endure (Chapter V)?
- Have MMCP's Consumer Action grants been effective in promoting consumer involvement in Medicaid managed care (Chapter VI)?

These chapters are followed by findings that are helpful in moving toward overall conclusions about MMCP. Chapter VII provides further insight into the accomplishments realized through grants and the potential trade-offs between grants and technical assistance. Chapter VIII considers whether core audiences (1) support MMCP, including their perceptions of strengths, weaknesses, and areas for desirable change and the importance of the area addressed by MMCP for the future, and (2) would be willing and able to provide support for it in the future.

The final chapter outlines conclusions and recommendations by spelling out what we regard as the major findings about MMCP's value. It also discusses what we have learned that RWJF might consider relevant as it considers the degree of importance to assign to MMCP in the future. Finally, we consider how the evaluation may shed light on broader issues of interest to RWJF.

III. IS MMCP PERCEIVED AS A VALUED RESOURCE BY CORE AUDIENCES AND OTHER KEY STAKEHOLDERS?

A. IMPORTANCE AND METHODS OF ASSESSMENT

For MMCP to have a fundamental impact on health care delivery, key audiences need to know of the program's existence, know what the program provides, and recognize the value of program activities. This chapter describes the evaluation's main findings on these issues, using two key measures to examine general awareness and perceptions across each relevant audience: (1) whether relevant audiences said that they were aware of MMCP and (2) what the audiences perceived about the uniqueness of what MMCP provides. The rest of the chapter focuses on MMCP's three core audiences: states, health plans, and consumer groups. It includes an assessment of the awareness of particular activities among the audiences followed by an audience-specific analysis of participation levels and intensity and consideration of how participants rate diverse activities and what audiences say about their use of MMCP versus other sources of information. We defer to later chapters an analysis of how participation influenced specific changes.

In general, the findings are derived from the previously described surveys of all members of each core audience regardless of their participation in MMCP. The findings are limited to self-reports, as is appropriate for the types of questions posed in this chapter. Given that respondents do not necessarily distinguish between MMCP and similar activities sponsored by CHCS but funded by other sources, the surveys referred to "CHCS." The findings therefore are not necessarily specific to MMCP, although MMCP was the dominant source of funding for work conducted by CHCS over the period covered by the evaluation, thus making it reasonable to rate MMCP based on the types of feedback reported here.

B. OVERALL AWARENESS AND PERCEPTIONS OF MMCP

Awareness levels among core audiences and other stakeholders involved in Medicaid managed care generally are high (see Table III.1). Eighty-seven percent of state directors and 88 percent of consumer groups reported that they were aware of CHCS. Awareness among health plans was somewhat lower (72 percent), reflecting the lower levels of awareness among commercial plans than Medicaid-dominant plans (58 versus 80 percent). Virtually all of the Medicaid policy analysts and Medicaid managed care researchers responding to the survey said that they were aware of CHCS. Only 75 percent of CMS staff were aware of CHCS, but awareness levels reached 92 percent among those noting that Medicaid managed care was a major focus of their work (versus 43 percent for whom Medicaid managed care was only a minor focus).

About three-quarters of those in the national audience said that CHCS provides something others do not.[12] Just under half of all surveyed health plans agreed with that statement, along with a similar proportion of consumer group respondents. Among Medicaid-dominant plans, assessments of CHCS' uniqueness are higher (56 versus 29 percent for commercial plans). Though state surveys did not elicit identical items, about seven out of every 10 Medicaid directors interviewed for the survey said that CHCS, or some of its activities, are unique. Among senior state staff surveyed, 28 percent said that the information or assistance available from CHCS is not available elsewhere.

[12] Respondents were asked to choose between this statement and three others: (1) CHCS provides no more or less valuable than other sources listed; (2) overall many sources are more valuable; and (3) others do it better. States and health plans were asked this question after they were asked to respond to items about their use of other sources of information. Consumer groups and others were asked this item on its own.

TABLE III.1

AWARENESS AND PERCEIVED UNIQUENESS OF CHCS BY GROUP

	Core Audiences					Other		
	State	Medicaid Plans			Consumer Groups	CMS	Medicaid Analysts	Researchers
		All	Medicaid-Dominant	Commercial				
Percentage aware of CHCS	87%	72%	80%	58%	88%	75%	97%	94%
Percentage aware of CHCS perceiving it as unique	--[a]	48%	56%	29%	47%	73%	74%	73%

Source: MPR surveys of core audiences 2003.

[a] Items not comparable. About 7 in 10 directors say CHCS or some of its activities, are unique. Slightly more than two-fifths (42 percent) say that if CHCS did not exist, they could not find the same help elsewhere; many others say that, without CHCS, they would have great difficulty finding needed assistance.

The following sections describe the awareness level of each core audience and how well MMCP has reached each audience; we also describe what the audiences think of the activities in which they are involved. We end with a brief review of how other stakeholders with an interest in Medicaid managed care view CHCS and its MMCP.

C. AWARENESS OF SPECIFIC ACTIVITIES BY CORE AUDIENCES

Core audience awareness of specific activities varied by audience and activity (see Table III.2). In general, states evidenced the highest level of awareness of activities, though awareness levels were lower among those below the state director level, probably reflecting the diversity of activities in which senior level state staff must involve themselves. Each audience was more aware of the major activity targeted to their type of organization than they were of the full spectrum of activities undertaken by MMCP. For example, state directors typically said that they were very aware (49 percent) of the Purchasing Institutes for which they were the core audience, but half that number (25 percent) said that they were very aware of BCAP. Most state directors

TABLE III.2

AWARENESS OF SELECTED CHCS ACTIVITIES BY RESPONDENT TYPE
(percentage of respondents)

Activity	State Medicaid Agencies		Health Plans		Consumer Groups[a]
	Directors	Senior Staff	All Plans	Medicaid-Dominant Plans Only	
Purchasing Institute					
Very	49	25	3	4	
Somewhat	28	24	16	20	73
A little	16	15	13	14	
Not at all	7	35	68	62	
Don't know	0	1	0	0	
BCAP					
Very	25	22	35	47	
Somewhat	37	26	15	12	80
A little	19	18	15	13	
Not at all	19	33	35	28	
Don't know	0	1	0	0	
Consumer Action Agenda					
Very	7	3	3	3	
Somewhat	28	18	15	16	93
A little	28	20	18	19	
Not at all	37	58	64	62	
Don't know	0	1	0	0	
Number	43	160	192	121	15

Source: MPR surveys of core audiences 2003.

[a]Consumer groups were asked only whether they were aware of each of these activities, not their level of awareness. BCAP. Most state directors knew something about BCAP, though awareness of specific activities varied among plans in their states (Draper and Gold 2004).

knew something about BCAP, though awareness of specific activities by plans in their states varied (Draper and Gold 2004).

Awareness levels among health plans were generally lower than among state Medicaid staff. Only 35 percent of all plans said that they were very aware of BCAP, including only 15 percent of commercial plans (versus 47 percent of Medicaid-dominant plans). Health plans also

typically did not know about activities targeted to other audiences (e.g., 68 percent said that they were not at all aware of the Purchasing Institutes, and 64 percent said that they knew nothing about the Consumer Action agenda).

Though few other groups were very aware of the Consumer Action agenda, consumer groups were aware of the agenda (93 percent) and also exhibited high awareness of the Purchasing Institutes and BCAP. For purposes of burden reduction, consumer groups responded to the shorter survey instrument developed for the national audience, and therefore questions on awareness of specific activities were limited to the three noted above.

We know more about states' and health plans' awareness of activities than others' level of awareness (see Table III.3). The data show that core state and health plan audiences are generally familiar with the major communication vehicles—publications, Web site, and monthly email newsletters. Yet, with only a little over half of surveyed senior state staff very or somewhat aware of resources, possibilities for improvement beckon. States were much more aware of grants and one-on-one technical assistance than health plans, perhaps because these resources have historically been much more available to and focused on states rather than plans. Awareness of MMCP activities was particularly low among commercial health plans, though 37 percent said that they were very or somewhat aware of BCAP.

D. REACH AND ASSESSMENT OF ACTIVITIES BY CORE AUDIENCE

1. State Medicaid Agencies

Our assessment of the reach and rating of CHCS activities by state staff is based on the Medicaid directors survey and survey of senior state staff. While the two surveys cover similar topics, the former involves open-ended responses and discussion. Additional detail on the findings reported here are available in Draper and Gold (2004).

TABLE III.3

AWARENESS OF SELECTED ACTIVITIES BY RESPONDENT TYPE
(percentage of respondents)

	State		Health Plans		
	Directors	Senior Staff	All	Medicaid-Dominant	Commercial
Publications					
Very/somewhat	81	64	45	56	10
A little/not at all/unknown	19	36	55	44	90
Web site					
Very/somewhat	63	56	44	54	27
A little/not at all/unknown	37	44	56	46	73
Monthly e-newsletters					
Very/somewhat	76	53	37	49	17
A little/not at all/unknown	24	47	63	51	83
One-on-one technical assistance					
Very/somewhat	60	34	14	24	6
A little/not at all/unknown	40	66	86	76	94
Grants					
Very/somewhat	65	60	32	40	17
A little/not at all/unknown	35	40	68	60	83
Number of respondents	(43)	(160)	(192)	(121)	(71)

Source: MPR surveys of core audiences 2003.

Reach and Participation. Virtually all states reported at least some awareness of CHCS, and most had participated in at least one activity (see Table III.4). All but one of the states responding to the survey had at least one staff member—a Medicaid director, senior program staff, or both—who was aware of CHCS; the one exception subsequently attended a Purchasing Institute. According to administrative records, among the 49 states and the District of Columbia with Medicaid managed care programs (exceptions are Alaska and Wyoming), two-thirds (33) had participated in at least one Purchasing Institute, a quarter (13) had received at least one grant, and 16 percent (8) had hosted on-site technical assistance visits. Seventy-six percent of states participated in at least one activity. States with lower levels of

TABLE III.4

SELECTED CHARACTERISTICS OF STATES PARTICIPATING WITH MMCP AS A PERCENT OF STATES ELIGIBLE TO PARTICIPATE[a,b]

State Characteristics	n	States Participating in Specific Activities as Percent of States: Any One of Three MMCP Activities (n=37)	Purchasing Institutes[c,d] (n=33)	Grants[e] (n=13)	On-Site Technical Assistance Visits[f] (n=8)
All States	49	76	67	27	16
Size of State Medicaid Population					
Small (< 200,000)	12	58	58	25	17
Medium (200,000-800,000)	21	86	67	38	19
Large (> 800,000)	16	75	75	13	13
Medicaid Managed Care Penetration[g]					
Low (< 25 percent)	4	25	25	0	0
Moderate (25-75 percent)	31	77	71	29	19
High (> 75 percent)	14	86	71	29	14
Medicaid Managed Care Program Type					
HMO only	19	89	84	32	21
PCCM only[h]	9	44	33	33	0
Combined HMO/PCCM	21	76	67	19	19
CMS Geographic Region					
Region I (Boston)	6	83	50	67	0
Region II (New York)	2	100	100	0	0
Region III (Philadelphia)	6	83	83	17	33
Region IV (Atlanta)	8	75	50	38	13
Region V (Chicago)	6	83	83	17	33
Region VI (Dallas)	5	60	60	20	0
Region VII (Kansas City)	4	75	75	25	25
Region VIII (Denver)	5	40	40	40	20
Region IX (San Francisco)	4	100	100	0	25
Region X (Seattle)	3	67	67	0	0

Sources: CMS 2002a (size of state Medicaid population, Medicaid managed care penetration); CMS 2002b (Medicaid managed care program type); CMS 2004 (CMS geographic region); Kaiser Family Foundation 2004 (SCHIP program type).

[a]Excludes Alaska and Wyoming, which have no Medicaid managed care programs.
[b]All states have access to CHCS, publications, newsletters, and Web site. This table reflects those activities that involved more active interaction with the states.
[c]Includes states participating in the RWJF-funded Purchasing Institutes, including the December 2001 Purchasing Institute cosponsored with CHCF and the Managed Care Performance Technical Assistance Series; excludes states participating as faculty only (see Table I.4 for additional details).
[d]CHCS has held two other Purchasing Institutes funded by sources other than RWJF and not included here: (1) Children with Special Needs, November 13–16, 2001, sponsored by The Annie E. Casey Foundation and (2) Substance Abuse, September 14–17, 2003, sponsored by the Technical Assistance Collaborative as part of the Resources for Recovery: State Practices that Expand Treatment Opportunities, an RWJF national grant program.
[e]The grants reflected here represent only those awarded to state government agencies.
[f]MMCP also provides telephonic technical assistance, which is not reflected here.

Medicaid managed care penetration and states that relied in primary care case management (PCCM) programs were less likely to participate, though many did.

Many states participated in several activities, with attendance at multiple Purchasing Institutes particularly high. Of the 33 states participating in Purchasing Institutes, only 10 participated in just one—12 participated in two and 11 participated in three or more. Seven states participating in purchasing activities also received grants, and six received technical assistance. Two states—Colorado and Maryland—participated in all three activities.

Assessment of Purchasing Institutes. MMCP Purchasing Institutes help states "improve their purchasing skills in response to the evolving marketplace." MMCP sponsored two types of Purchasing Institutes—general institutes covering numerous topics over a several-day period and targeted institutes focusing on a particular topic over a longer period. In each case, participating states bring a core team of staff members (two to four, ideally including the director) and focus on identifying improvements to be made in their own state.

Survey respondents participating in the institutes rated them highly (see Table III.5). At least 70 percent of attendees rated their particular workshop as excellent. State directors most commonly said that they participated because the relevancy, timing, and nature of the topic(s) matched the state's focus and because the institutes provided an opportunity to learn from other states. They also said that the institutes offered training opportunities for staff, helped compensate for expertise lacking within the state, fostered team building, and freed staff of day-to-day obligations so that they could focus on important issues. Virtually all of the senior staff attending the institutes said that the institutes left them better informed and helped them forge new contacts; 85 percent said that the institutes helped them identify specific changes needed in their state, 76 percent reported that the institutes helped them learn new skills, and 71 percent initiated a process to consider changing specific aspects of their program. Those not attending

TABLE III.5

SENIOR PROGRAM STAFF EVALUATION OF MMCP-FUNDED PURCHASING INSTITUTES

Purchasing Institute	Percent Attended[a]	Percent Rating Purchasing Institute as…. Excellent	Good	Fair	Poor	Don't Know/No Answer
Princeton, NJ–March 2000 or November 2000	17	78	18	4	0	0
Berkeley, CA–December 2001	8	82	9	0	0	9
New Orleans, LA, Monitoring Managed Care Performance Workgroup–May/October 2002	6	75	25	0	0	0
Kansas City, MO, Rewarding Managed Care Performance Workgroup—September 2002	7	70	20	0	0	10

Source: MPR analysis of survey data.

Note: CHCS has also held two other Purchasing Institutes funded by sources other than RWJF that are not included here: (1) Children with Special Needs, November 13–16, 2001, sponsored by The Annie E. Casey Foundation and (2) Substance Abuse, September 14–17, 2003, sponsored by the Technical Assistance Collaborative as part of the Resources for Recovery: State Practices that Expand Treatment Opportunities, an RWJF national grant program. In addition, the Purchasing Institute held in Colorado Springs in October 2003 is not reflected here, as the survey was conducted before the institute was held.

[b]A total 41 of 135 respondents (30 percent) reported attending at least one of the Purchasing Institutes reflected here.

attributed their absence to lack of awareness of the institutes, budgetary or travel constraints, competing workload obligations, or lack of relevance or need (e.g., little managed care purchasing in the state).

Grants. MMCP awarded a total of 17 grants to 13 states between 1995 and 2003. As described in Chapter I, MMCP offers two main types of grants: large model demonstration grants and smaller best practices/policy grants. States are a prime target for the grants, particularly demonstration grants. While not always successful in their grant applications, over a third (35 percent) of Medicaid directors interviewed for the evaluation said that their state had

applied for a grant from MMCP, as did 27 percent of surveyed program staff. States said that they apply for grants for a variety of purposes that generally involve efforts aimed at revamping their programs to encourage more use of managed care, developing targeted managed care initiatives, implementing technical systems needed by programs (e.g., risk adjustment, indicator systems), or conducting legislatively mandated studies. States view the availability of MMCP grants as important, with 56 percent of directors saying that the grants are very important (Draper and Gold 2004). Given that MMCP has been moving to merge grants with technical assistance activities, we asked directors to respond to the concept. If they had a choice, 33 percent of directors said that they would prefer independently awarded grants, 33 percent would prefer grants associated with a targeted workshop, 11 percent would prefer both, and 23 percent had no opinion.

Technical Assistance. MMCP's movement toward a technical assistance strategy was originally based on free-standing work with states but over time has transitioned to include more group-based support linked to Purchasing Institutes. Consequently, a larger number of states (11) see themselves as receiving one-on-one assistance than is reflected by the administrative data showing seven states in receipt of assistance. Examples of the types of help states said they received include help with value-based purchasing (including the procurement process), risk adjustment, program restructuring, pharmacy purchasing, disease management, performance measurement and monitoring, and care management for high-cost individuals. Directors whose states had received assistance generally found it very helpful. For example, one director said, "It allowed us to get something up and running in less than four months." Another director said, "The assistance was very important because we didn't want to have to reinvent the wheel." Of 25 senior program staff with personal experience with technical assistance, 64 percent found it "very useful."

Other Activities. In addition to the previously described activities, MMCP supports its core audiences by making information available on the CHCS Web site through publications and in monthly newsletters. States view the Web site and publications as valuable but are somewhat less enthusiastic over the monthly newsletter.

Over half (56 percent) of Medicaid directors and 68 percent of senior staff surveyed for the evaluation said that they have accessed the Web site. Directors most commonly said that they use the Web site as a resource center or to obtain publications. Senior staff do so as well and indicated that the site also is useful in providing information on managed care best practices. Respondents generally viewed the Web site as easy to access. One director said, for example, "When I go to find something, it's usually there"; another said that "I think it's one of the two or three best in the country." One of the site's best features is its impartiality, particularly in an era when, in directors' minds, so many sites reflect an advocacy position. However some directors noted that the site could be better marketed.

States appear to access CHCS publications extensively. Eighty-six percent of directors and 68 percent of senior staff surveyed for the evaluation said they received such publications, typically by mail, though, as noted, Web access also is available. Over 90 percent of senior staff receiving the publications said that they review the contents and read items of interest, and almost as many (88 percent) said that they circulate the materials to staff. Directors virtually always circulate the publications (97 percent), but most also said that they review the contents (76 percent) or read articles of interest (73 percent). While states generally take a favorable view of the topics covered in the publications, both directors and staff point to the need for improvement; both groups were much more likely to say that the topics covered are "somewhat" versus "very" useful (see Table III.6).

TABLE III.6

STATES' USE AND ASSESSMENT OF CHCS PUBLICATIONS

	Medicaid Director	Senior Program Staff
Percent that		
Receive publications from CHCS	86	68
(number of respondents)	(43)	(135)
What most commonly do with publications (percent)[a]		
Review contents	76	93
Read items of interest	73	93
Circulate to staff to whom items appear relevant	97	88
Ask staff to review and summarize for me, then read items of interest	8	10
Nothing,, too busy, and do not get around to it	5	5
Usefulness of topics covered (percent)		
Very	40	24
Somewhat	51	60
A little	3	11
Not at all	3	0
Don't know/no answer	3	5
(number of respondents)	(37)	(92)

Source: MPR analysis of survey data.

[a]Does not add up to 100 percent because respondents were asked for all that apply.

When we conducted our survey, CHCS distributed both a general monthly e-mail newsletter and three additional newsletters that separately targeted each core constituency (these separate newsletters have since been merged). Even though 63 percent of Medicaid directors said that they received the newsletters, they also said that some were more interesting than others depending on the contents. Several noted that they are inundated with electronic information, making it difficult to differentiate the source. Senior staff surveyed similarly noted high rates of newsletter receipt (74 percent received at least one of the monthly newsletters), but more than half said that they read them "no more than occasionally"; only 13 percent found them very useful.

Overall Uniqueness. State directors and staff reported that they commonly access a variety of sources of information to support their work in Medicaid managed care, including materials published by the National Academy for State Health Policy, the Kaiser Commission for Medicaid and the Uninsured, the Robert Wood Johnson Foundation, CMS, the National Governors Association, and others such as the Agency for Healthcare Research and Quality. But the states also believed that CHCS provides something others do not, including "more hands-on help," resources that support a "structured faculty-type program," and good customer service that is "responsive to (state) questions." Even more so than directors, senior staff commended CHCS' hands-on help that involved "technical assistance beyond advice on the telephone." If CHCS did not exist, 42 percent of directors said that they "would be unable" to obtain the same type of help elsewhere, 44 percent said that they would we able to obtain the needed assistance, and 14 percent said they did not know. Among those acknowledging that they might be able to obtain help elsewhere, they agreed that the search for such help would be both difficult and time-consuming. For example, they might have to turn to consultants, an unlikely prospect given the current state budget climate. In addition, without CHCS, states would be unlikely to convene and learn from one another.

2. Medicaid Managed Care Health Plans

CHCS worked closely with the states under the aegis of MMCP from its start in 1995 and did not turn its attention to health plans until the late 1990s. While CHCS viewed itself as relatively well known to states, it recognized that its involvement with health plans posed a large challenge. Plans were less likely than states to look to foundations for assistance and thus would be less aware of both RWJF and CHCS.

The strategy CHCS developed to address this challenge called for attracting plans through work focused on the Best Clinical and Administrative Practices (BCAP) initiative. Intensive

workgroups generally involving about 12 health plans convened in a series of meetings over nine to 12 months to develop, pilot, and refine best practice models for specific issues in managed care. At the time of our survey, MMCP had convened or was in the midst of convening five such workgroups focused, respectively, on improving birth outcomes, improving asthma care, and increasing rates of preventive care services for children, providing care for children with special health care needs, and providing care for adults with chronic illness or disability. Workshops follow the workgroups and involve two-day meetings in which health plans learn about the particular best practice models developed in the workgroups. The workshops typically involve about 30 health plans and have addressed the first three BCAP topic areas. In addition, CHCS publishes a "toolkit" after each workgroup for dissemination to plans and others interested in a given issue. To increase awareness of the workgroup and workshop activities, CHCS convened a Quality Summit in October 2002; state health plans, along with a few other participants from primary care case management programs and state Medicaid agencies, participated and learned about various improvement approaches in use.

Our nationwide survey of health plans participating in managed care in late 2003 provides the basis for insights into how such plans view MMCP. At the time of our survey, we identified 224 Medicaid managed care plans, of which 192 responded to our questions. For 63 percent of the plans, 75 percent or more of their enrollees were in Medicaid or, less frequently, similar public programs, (which we define as Medicaid-dominant plans). Responding plans spanned 38 states, though one-third operated in New York, California, Michigan, and Florida. Seventy-one percent counted 25,000 Medicaid/SCHIP members or more, including 30 percent with 100,000 such members. Additional details on the findings are available in Taylor and Gold (2004).

Reach and Participation. Forty-two percent of all health plans participating in Medicaid manage care (95 plans) had participated in CHCS activities as of late 2003, according to

administrative records; these plans span 30 states.[13] However, only 31 percent of health plans responding to the survey reported participating in one or more CHCS activities, including BCAP workgroups or workshops, the Quality Summit, receipt of grants, and technical assistance.[14,15] Plan-reported participation extends to 59 health plans, including 50 Medicaid-dominant plans and nine commercial plans. These plans span 26 states and appear to include at least 5 million Medicaid and SCHIP enrollees. Plan-reported participation rates are substantially higher among Medicaid-dominant than commercial plans (41 versus 13 percent). Plans heavily reliant on Medicaid account for most of the health plan audience reached by MMCP.[16]

BCAP-related participation dominated responding health plans' involvement in MMCP (see Table III.7). Only three health plans that had not participated in some form of BCAP-related activity received a grant, and none received one-on-one technical assistance. In contrast, approximately 20 percent participated in a BCAP workgroup and 16 percent in a BCAP workshop. Moreover, nearly 50 percent of plans participated in two or more categories of activities, suggesting that a number of plans make intensive use of MMCP.

[13] This estimate is based on the plan definitions used to define plans designed for the survey and excludes specialty plans (e.g., behavioral health demonstration) and non-capitated programs based on primary care case managed care.

[14] Respondents from 26 plans reported that their plan had not participated in any CHCS activities, whereas administrative records indicated otherwise. This difference could reflect staff turnover and lack of transmitted knowledge, involvement of another part of the organization, or some other reason.

[15] Thirty-eight percent of surveyed plans reported such participation, but in some cases the self-report conflicts with the administrative data we collected on participation. Some respondents confused workgroups with workshops, or the Quality Summit with either of these. Some reporting participation appear to have been referring to similar groups run by CHCS under the sponsorship of other foundations, particularly the California BCAP Asthma Collaborative and New Jersey BCAP child outcomes collaborative. The findings we report here are based on validated resources that include only health plans known to have participated. Compared with unvalidated data the validated data generally provide similar or more positive assessments of CHCS (see Taylor and Gold 2004).

[16] This is even more the case as four of the nine commercial plans participating in MMCP activities had Medicaid/SCHIP enrollments between 50 and 74 percent of total enrollment. The participation rate among commercial plans in which Medicaid/SCHIP is less than half of the total enrollment (as it is in most commercial plans) was under 9 percent.

TABLE III.7

COMBINATIONS OF CHCS ACTIVITIES AMONG HEALTH PLANS THAT PARTICIPATED IN ONE OR MORE ACTIVITIES
(validated survey results)

CHCS Activity	Percent of Health Plans (n=59)
One Type of Activity Only	52%
BCAP workgroups	27
BCAP workshops	12
Quality Summit	10
One-on-one technical assistance	0
Grants	3
Combinations of Activities	48%
Workgroups/workshops only	14
Workgroups/workshops and Quality Summit	17
Workgroups/workshops and one-on-one technical assistance	8
Workgroups/workshops and grants	7
Workgroups/workshops, Quality Summit, and one-on-one technical assistance	0
Workgroups/workshops, Quality Summit, and grants	0
Workgroups/workshops, one-on-one technical assistance, and grants	2

Source: MPR analysis of health plan survey data.

Few plans that did not participate in a workgroup said they had applied to participate; around 60 percent of nonparticipants—particularly Medicaid-dominant and commercial plans—said that they did not participate because they were not aware of the workshops. Commercialplans were more likely to cite duplication of current participation in other similar workgroups as the reason for nonparticipating while lack of time or resources loomed as a larger factor for Medicaid-dominant plans.

Assessment of BCAP Activities. Plans participating in the various workgroups and workshops generally gave the activities a high rating (see Table III.8). Almost none of the plans rated any of the activities as fair or poor. As for workgroup participants, at least half of

TABLE III.8

RATINGS OF BCAP WORKGROUPS AND WORKSHOPS AMONG PARTICIPATING PLANS
(validated survey results)

	Percent of Participating Health Plans			
	Excellent	Good	Fair	Poor
Workgroups:				
Birth outcomes (n=5)	60	40	--	--
Preventive Care for Children (n=6)	50	50	--	--
Asthma (n=16)	75	19	6	--
CSHCN (n=8)	75	25	--	--
Chronic Illness and Disabilities (n=7)	57	43	--	--
Workshops:				
Birth outcomes (n=14)[a]	43	43	--	--
Preventive Care for Children (n=11)	55	45	--	--
Asthma (n=15)[a]	67	20	7	--

Source: MPR analysis of health plan survey data.

[a]Percentages do not add up to 100 percent because of missing values ("don't knows").

participating plans rated each workgroup as excellent while 75 percent of responding plans rated the workgroups on asthma and children with special needs as excellent. Ratings for workshops were somewhat lower, but the proportion of participants rating them excellent steadily increased from the first workshop on birth outcomes (43 percent) to the third one on asthma (64 percent). Fifty-five percent of those who participated in a workgroup said that they would definitely participate in another workgroup, and 60 percent of those who participated in workshops said that they, too, would definitely participate in another workshop. Attendees of the Quality Summit found that event useful, with two-thirds saying that it was extremely useful. At least four-fifths of participants reported that the summit helped them forge new professional contacts, become more informed, acquire new skills, and work with others in the plan to introduce change.

Assessment of Grants. CHCS hoped that BCAP would make plans more aware of MMCP's grant opportunities. Still, fewer than half (47 percent) of surveyed health plans were aware of the availability of MMCP grants. In total, 31 plans reported applying for one or more grants, with 7 awarded, all to Medicaid-dominant plans. Perhaps reflecting their limited visibility and low rate of proposal success, MMCP grants do not appear to be very important to health plans. Even among those applying for such grants, only 61 percent said that they were very or somewhat important to their plan.

Assessment of Technical Assistance. MMCP provided one-on-one technical assistance to few plans outside the BCAP environment. CHCS said that six plans received such assistance.[17] Three plans in the survey said that they received such assistance, with one saying that it was somewhat useful and another a little useful. Thus, the TA element of the program (outside of BCAP) seems of limited relevance in assessing MMCP's work with health plans.

Other Activities. Other activities include the published BCAP toolkits, additional publications, the Web site, and electronic newsletters. The toolkits are probably the most visible of the products targeted to health plans. About 45 percent of plans responding to the survey reported that they were familiar with one or more of the BCAP toolkits. Of those, 84 percent rated the toolkits as extremely or somewhat useful. The toolkits allowed CHCS to reach another 30 plans (or 16 percent of plans responding to the survey) that had not participated directly in the previously mentioned CHCS activities. Those familiar with the toolkits were more likely to say they were very useful in providing information than for other purposes. But 60 percent or more also said the toolkits were very or somewhat useful for acquiring new skills, identifying specific changes needed in the plan, outlining a specific process for change, or making specific changes.

[17] MMCP may sometimes work with associated plan sponsors or provider groups that are not the same as the plan entity surveyed.

Publications also appear to be valuable in reaching plans. Forty-five percent of survey respondents reported that they received publications from CHCS, including a third of plans (34) that had not participated in other BCAP activities. Most plans receive the publications by mail though almost an equal share receives them by email. Thirty-eight percent of plans acknowledging receipt of publications found the materials very useful and another 46 percent found them someone useful.

A smaller though not insignificant share of plans use CHCS' other sources of information. About 42 percent of plans (81 plans) said that they have accessed the Web site, though many access it on an infrequent basis. Plans tend to use the Web site to obtain information on managed care best practices and publications. About 39 percent of plans reported that they received monthly electronic newsletters; of these plans, about half read them every or most months. Though 74 percent of those receiving the newsletters said that they are very or somewhat useful, ratings tend to be lower than for hard-copy publications.

Overall Uniqueness. Health plans in Medicaid turn to a variety of information sources beyond MMCP, including (in descending order of use) the National Committee for Quality Assurance, the American Association of Health Plans (now American Health Insurance Plans), the Institute for Healthcare Improvement, the Joint Commission on the Accreditation of Healthcare Organizations, the Institute for Healthcare Improvement, the American Hospital Association, the Kaiser Commission on Medicaid and the Uninsured, and others. Both Medicaid-dominant and commercial plans said that they use the information provided by these various organizations. Nonetheless, health plans—particularly Medicaid-dominant plans (56 versus 29 percent for commercial plans)—viewed CHCS as providing resources not available from other organizations. For many plans as opposed to states, MMCP appears to be a less vital source of information, with 43 percent of plans saying that they could obtain such information

elsewhere. MMCP, however, has reached a sizeable number of mostly Medicaid-dominant plans that tend to provide "repeat business." These, apparently, are the group of Medicaid participating health plans that find MMCP unique and particularly valuable.

3. Consumer Groups

While MMCP views consumer groups as its third core audience, CHCS has invested substantially fewer resources in reaching consumer groups and addressing the Consumer Action agenda (McHugh 2004). The purpose of the Consumer Action agenda is (1) to help consumers and their families navigate publicly financed managed care systems and (2) to institutionalize a role for consumers in the design, implementation, and evaluation of publicly financed managed care programs to ensure that programs respond to children's needs. Funds from The Annie E. Casey Foundation's Children in Managed Care Initiative complement MMCP funds to support the Consumer Action agenda. A seven-member national steering committee, including staff from major national consumer organizations and diverse locally based programs, guided MMCP's work on the agenda. A consumer leadership meeting in 2000 led to the development of Consumer Action seed grants. The two-round grant program aimed to support innovative local projects to strengthen consumer and family understanding of and involvement in publicly financed managed care. The first round of grants, with awards up to $25,000 each, was made by the program between March and September 2001, followed by a second round (up to $50,000) a year later.

To gain perspective on how consumer groups viewed MMCP, we developed a list of consumer organizations, reviewed and revised the list with help from CHCS and RWJF, and surveyed the organizations on the list as part of the national audience questionnaire. Though some surveyed groups had participated in MMCP activities, others had not; we therefore aimed to include both types of organizations in the survey sample. Additional detail on survey

responses is available in Krissik and Gold (2004), with more detail on the Consumer Action agenda covered in McHugh (2004).

Reach and Participation. In the absence of a master list specifying the organizations and individuals who constitute the universe of consumerism, the concepts of reach and participation are less easily applied to the Consumer Action agenda. Those included in our survey sample frame reflect major leaders in the field and well-known organizations with a general focus such as the Children's Defense Fund, Families USA, Consumers Union, and Family Voices; specialized advocacy groups such as the Council for Disability Rights, National Council of La Raza, and the National Health Law Program; and geographically focused groups such as the Michigan Disability Rights Coalition, the Oregon Health Action Campaign, and the Tennessee Justice Center.

Among the organizations listed above, awareness of MMCP tends to be very high. Of the 17 survey respondents representing consumer groups, 15 were aware of CHCS. Among these individuals, 60 percent said that CHCS was a very important resource for finding out about specific ways to improve Medicaid managed care, and 53 percent said that it was a very important resource for keeping abreast of state practices. While 47 percent said that CHCS was very important as a source of technical assistance and training, only 33 percent thought it was, respectively, very important as a source of contacts or as a provider of grant funds.

If a surveyed consumer (or other) organization was aware of CHCS and said that CHCS' work involved consumer advocacy, access, or navigation issues, we also asked the organization about the Consumer Action agenda. Almost all the queried consumer respondents (86 percent) were aware of the Consumer Action grants. Ninety-two percent had recommended that an affiliate, partner, or constituent group apply for such a grant, and half of the respondents had applied for one themselves, of whom half (three of six) received one. Awareness of Consumer

Action grants was much lower among others in the national audience who similarly replied that their work involved consumer advocacy, access, or navigation issues. Only 42 percent of such individuals (15 of 36) were aware of the grants; six said that they advised another organization to apply for one. As noted, 37 percent of states said that they were not at all aware of the Consumer Action agenda activity, and another 28 percent were only a little aware. Among health plans, almost two-thirds (64 percent) were not at all aware of the Consumer Action activities, and another 18 percent were only somewhat aware. Hence, while the Consumer Action agenda appears to be visible among major consumer groups, it is relatively invisible among other groups as an MMCP activity.

Assessment of Consumer Action Grants. Both consumer groups and others in the national audience survey were asked about the Consumer Action grants if their responsibilities involved advocacy (self-defined). Those with knowledge of these grants were then asked for a rating on their focus, available resources, grantee selection, and grant outcomes. Most ratings were good rather than excellent, suggesting support for the programs but a sense they could be improved (see Table III.9). Ratings related to the focus of the grants tended to be the most positive while those related to available resources tended to be the most negative. Recommendations for change typically revolved around the need to offer more and longer grants, identification of what consumers need (versus what states think they need), more aggressive outreach to groups, and additional grassroots advocacy.

To provide additional insight into general impressions of the grants, we interviewed grant recipients. The recipients typically said that the grants were tremendously important to their organizations. Indeed, only one of the 18 respondents said their organization would have been able to conduct the project activities in the absence of the grants. Chapter V presents additional information on the focus and outcomes of the grants.

TABLE III.9

CHCS STAKEHOLDERS' ASSESSMENT OF CONSUMER ACTION GRANTS

Dimension and Rating	Consumer Groups n=12	Others in National Audience n=15
Focus		
Excellent	4	4
Good	4	5
Fair	2	0
Poor	0	0
Available Resources		
Excellent	2	3
Good	6	7
Fair	3	0
Poor	0	0
Grantee Selection		
Excellent	2	5
Good	7	3
Fair	1	0
Poor	0	0
Grant Outcomes		
Excellent	3	3
Good	4	4
Fair	2	0
Poor	0	0

Source: 2003 MPR survey of CHCS stakeholders.

Note: These items were asked of individuals who indicated that their work involved consumer advocacy, navigation, or similar responsibility, and that they were aware of the Consumer Action agenda. Twelve consumer group respondents answered these questions, along with 15 other types of respondents (CMS staff, Medicaid researchers, and analytic Medicaid or SCHIP policy staff).

Other Activities. Consumer groups surveyed for the evaluation ranked the importance of other, though not all, MMCP activities, particularly BCAP and the Purchasing Institutes. Though awareness levels of these activities tended to be high, the activities earned a lower rating on importance as compared with the Consumer Action grants. BCAP's importance received a higher rating than state Purchasing Institutes, with 58 percent of respondents viewing BCAP as

somewhat or very important and 36 percent viewing the Purchasing Institutes as somewhat or very important.

Across all three surveys, most answers to questions asking respondents to rate whether MMCP put too much, the right amount, or too little focus on specific activity areas generally did not prove particularly useful—respondents either did not know or said that current levels were just about right. The fact that 53 percent of the surveyed consumer groups said that the current level of attention to the Consumer Action agenda was too little, and that 40 percent said the same about grants is therefore notable. Consumer group respondents recommended more activities with consumer groups (seven), more grant activity included increased targeted grant making (three) and increased outreach activities to inform people about what CHCS does (two), among other suggestions.

Overall Uniqueness. Consumer groups typically do not look first to MMCP for information, though the groups find that the information made available by MMCP is useful. Only 47 percent of consumer respondents perceived that MMCP provides services and products not available from other sources, though most of the rest (33 percent) of the respondents said that MMCP proved about as valuable as other sources. Almost half of consumer groups (46 percent) tap into sources of information *other* than Kaiser Family Foundation, CHCS (20 percent), CMS, or state agencies. As we discuss later, few sources of support are available to advocacy groups seeking to help consumers navigate the health care system. Those advocating for consumers would like to see MMCP do more in the area of Consumer Action.

E. OTHER AUDIENCES AND WHAT THEY FIND OF MOST VALUE

Though not core MMCP audiences, CMS, Medicaid policy analysts, and those involved in Medicaid managed care research are important stakeholders in Medicaid managed care, and it is

valuable to understand what they find of most value from MMCP program. This discussion is based on the national audience survey (for additional survey results, see Krissik and Gold 2004).

CMS Staff. Medicaid managed care is joint federal-state program. While states administer the program, the federal government maintains an active interest in program operations. Within CMS, the central office pursues certain responsibilities, whereas the regional offices are involved in day-to-day monitoring of states' general activities. The 22 CMS respondents in our survey include 12 from the central office and 10 from the regional offices (one from each region). At the inception of MMCP, CHCS perceived a high degree of conflict and mistrust between the states and federal government and therefore introduced activities that distanced the states from the federal agencies. Though CMS is not a focus of MMCP work, CMS staff make use of the information available from MMCP; 60 percent viewed it as very important in keeping up with state practices, 60 percent saw it as very important in finding out about specific ways to improve Medicaid managed care, and 40 percent saw it as a source of contacts. When used, however, CHCS' information tended to complement CMS' own information that it collects from states and others. Some CMS respondents said that they hoped for an increased involvement with CHCS in the future.

Medicaid Analysts. Medicaid analysts include staff from a diverse set of national public and private organizations concerned about policy issues associated with Medicaid managed care. Examples include the Alliance for Health Reform, Congressional Research Service, The Commonwealth Fund, and The Annie E. Casey Foundation. Included, too, are the national groups representing some of MMCP's primary constituents (health plan associations and state health policy organizations). Among the Medicaid analysts surveyed, 42 percent work for nongovernmental programs with a national focus, 17 percent in similar organizations with a regional/state focus, 16 percent in universities, and 11 percent in federal agencies other than

CMS, among others. Medicaid managed care typically represents only part of their work or interests.

Awareness of MMCP is very high among Medicaid analysts, but the diversity within the group of analysts means that awareness of specific activities varies widely as do assessments of the importance of the activities. For example, 17 percent said that technical assistance/training are very important and 20 percent said that grant funds are very important, but at the same time 43 percent said technical assistance/training was not important at all and 54 percent said the same about grants. A small minority (17 percent) relied on CHCS as their main source of information, but most said that CHCS provides information not otherwise available and most of the rest said it has about the same value as other sources of information.

Medicaid Researchers. The 16 researchers participating in the national audience survey were deliberately selected for the sample because of their involvement in applied work relating to Medicaid managed care, though (from their survey responses) the researchers rarely viewed Medicaid managed care as the major focus of their work. Most of the researchers worked outside academia, often in independent public policy research firms. Those who had been eligible for or had received the smaller policy research grants from MMCP were more likely to view grant funds as important. Among researchers, about a quarter (27 percent) said that CHCS is their primary source of information, though an equal share said that other sources were of greater value. CHCS' publications and the Web site seem of particular value to this group. Recommendations for improvements tended to focus on more support to state agencies in improving Medicaid managed care.

F. SUMMARY OF FINDINGS

In reviewing the findings from the MPR evaluation, this chapter discussed whether MMCP's core audiences—states, health plans, and consumer groups—and others with an interest in

Medicaid managed care view MMCP as a valued resource. The results of the national surveys of the three audiences demonstrate that MMCP has earned favorable ratings among its clientele. Core audiences, as well as others with an interest in Medicaid managed care, are generally aware of CHCS and its work in Medicaid managed care. While a variety of sources of information are available, a substantial share of survey respondents perceive that CHCS provides something that others do not.

Clearly, MMCP has reached its core audiences, and participants generally assign a high grade to MMCP activities. Two-thirds of states participated in one or more Purchasing Institutes, and 75 percent participated in the institutes and/or in grants or technical assistance activities. Participants in these activities overwhelmingly rate them as excellent. Overall, about 42 percent of Medicaid managed care plans participated in one or more of the plan-focused MMCP activities (BCAP workgroup or workshops, Quality Summit, grants, or technical assistance) by the end of 2003. A majority or more of those in workgroups and workshops and responding to the survey rated the activities as excellent, and almost all other participants rated them as good. Awareness levels of the Consumer Action grants were similarly high among consumer groups, which gave the grants a very favorable ranking.

The survey findings also highlight areas for attention. Among Medicaid health plans, those focusing most heavily on Medicaid (Medicaid-dominant plans) are much more aware of MMCP than commercial plans, much more likely to participate in MMCP activities, and much more likely to say that MMCP is a unique resource. With such plans becoming a more dominant presence in Medicaid managed care, the findings are not surprising, particularly given that quality initiatives developed to support commercial practice have not historically emphasized issues of likely importance to the Medicaid commercial sector. The findings also highlight the uneven level of awareness of MMCP activities. For the most part, each audience is most aware

of activities directly related to its interests and therefore less aware of MMCP's overall breadth. If the program develops activities aimed at integrating its diverse stakeholders, it might bump up against barriers in the form of various interest-focused audiences who may be surprised to learn of the full scope of interest in MMCP. Finally, the survey findings show that those outside MMCP's core audiences also have an interest in the program's future. It may make sense to revisit how MMCP might best relate to CMS, both in the central and regional offices, as staff in Medicaid managed care appear to have a strong interest in MMCP's work.

IV. HAS MMCP HELPED STATES BECOME BETTER PURCHASERS, AND WILL ANY CHANGES ENDURE?

A. IMPORTANCE AND METHODS OF ASSESSMENT

Though core audiences' awareness and perceptions of and participation in MMCP are important, foundation and program staff ultimately want to know whether MMCP has made a difference. This chapter, the first of three that focus in turn on states, health plans, and consumers, presents the evaluation's findings on MMCP's impact. While specifics vary across the audiences, assessments for each audience are based on (1) the extent to which each survey reported change; (2) in-depth analysis of the changes reported by those most actively engaged in the program, the role of MMCP in generating those changes, and the sustainability of the changes; and (3) other available information on the extent of movement toward program goals over the span of the program and whether MMCP can claim responsibility for it.

In the case of states, the survey included a general item asking state directors if MMCP motivated them to make concrete changes in their programs and, if so, the nature of the changes. To interpret responses as fully as possible (see Krissik and Au 2004), we reviewed the changes to determine if they appeared to involve a concrete and specific change (e.g., developing a new purchasing strategy, streamlining the SCHIP and Medicaid program) or something more general that could be important but may be difficult to validate (e.g., thought about program differently, received reinforcement of initiatives already underway). We also examined the responses of state directors with respect to changes resulting from the Purchasing Institutes, technical assistance, or grants, concluding that little had been lost by focusing on the general item.[18]

[18] The states indicating that they made concrete changes in response to the Purchasing Institute or technical assistance were included in the states that responded in general that they made a change. Three additional states indicated they made changes solely through grants, but one was still in process, another stagnated after initial

We reviewed the available information for each of the states involved in making concrete changes, contacting three for which existing information was judged inadequate and obtaining recent information from another two that were included as part of our reinterview of state directors in states with staff turnover. The interviews also provided insight into whether the results of the 2003 survey still were valid given the turnover in directors that year and whether changes were sustained. We gained still more insight into change and sustainability from the 2003 survey, which queried state staff on the barriers to development of Medicaid managed care.

B. EXTENT OF CHANGE ACROSS STATES PARTICIPATING IN MMCP

1. Overview

Twenty-four states surveyed in 2003 said that they made concrete improvements in their Medicaid managed care programs as a result of working with MMCP, a relatively high number that reflects half of the states with Medicaid managed care programs (see Table II.1 in Krissik and Au 2004 for additional details). Based on state-provided information, we judged that 14 states reported changes that, though important, did not qualify as identifiable concrete change. For example, the states might have said that participation "fortified staff" or that CHCS "validated" what states were doing or "gave them ideas." Ten states, however, named one or more concrete changes.[19] These states had been closely involved with MMCP. Each had participated in at least one Purchasing Institute, with four of them attending three or more (see Table IV.1). Five received on-site technical assistance, and six received grants, with two

(continued)
interest and focus, and a third involved a grant awarded earlier than the 2000 cut-off point used in our analysis (1998).

[19] These states exclude a state that reported change in the interview but has since dropped its Medicaid managed care program. However, we included State B even though it did not report change in the interview. At that time, it was awaiting a CHCS site visit, and we had heard from CHCS that it had worked intensively with the state over the past year. There could be additional states that instituted change after the survey was fielded.

TABLE IV.1

PARTICIPATION IN MMCP PURCHASING INSTITUTES, GRANTS, AND TECHNICAL ASSISTANCE ACTIVITIES AMONG STATES WITH SPECIFIC CONCRETE CHANGES

State	Number of Purchasing Institutes[a]	Number of On-Site Technical Assistance Visits	Number of MMCP Grants	MMCP Grant Type
Number of states with concrete changes	10	6	8	
A	3	0	0	
B	1	2	0	
C	2	1	0	
D	4	1	2	Model demonstration, Olmstead grant
E	1	0	1[b]	Model demonstration grant
F	2	1	1[b]	Model demonstration grant
G	2	1	0	
H	1	0	1	Model demonstration grant
I	3	0	2	Model demonstration, Olmstead grant
J	4	0	1	Planning grant

Source: MPR analysis of MMCP/CHCS documentation on grants and on-site technical assistance visits.

[a]Includes states participating in the RWJF-funded Purchasing Institutes, including the December 2001 Purchasing Institute cosponsored with CHCF and the Managed Care Performance Technical Assistance Series. CHCS also held two other Purchasing Institutes funded by sources other than RWJF that are not included here: (1) Children with Special Needs, sponsored by The Annie E. Casey Foundation and (2) Substance Abuse, sponsored by the Technical Assistance Collaborative.

[b]Note that an organization that works closely with the state received this grant.

participating in all three types of activities. States said that the activities were important in supporting their initiatives. After reviewing available information from past or recent interviews, we concluded that all but one of these states did in fact make concrete changes as a result of participation. The exception (State I) developed but was ultimately unable to implement its model for improved delivery partly because of budget problems. Below, we provide a brief summary of each of the state's changes and what we know about their sustainability.

2. Specific Concrete Changes Made by States

State A. Working with CHCS through a number of Purchasing Institutes and the recipient of technical assistance, this large state's Medicaid program developed a monitoring report—"The Dashboard Project"—for use in measuring Medicaid managed care performance in five areas: demographics, service utilization, encounter data, financial stability, and member services. The state has also recently publicly released some HEDIS data. Staff say that the project has "completely changed how we do business," evoking much more of a partnership with plans and a focus on what is important—quality of care. Despite a change in program leadership, the system was still operating when we contacted the state in fall 2004.

State B. This state initiated its work with CHCS relatively recently with the arrival of a new director. The director regarded the state as somewhat behind other states in its approach to Medicaid managed care and aimed to align the state with current Medicaid managed care approaches and practice. Working with CHCS, State B developed and published on its Web site a Medicaid managed care "report card" highlighting the program's achievements in such areas as member satisfaction, quality of care, and access. The state said that consumers' and health plans' initial public reaction to the report card was positive; the state now intends to publish one annually. Initially unsuccessful in its efforts to develop a small risk-based program for the elderly, blind, and disabled Medicaid population, the Medicaid agency also has worked with

State B's Department of Public Health to develop a community-based approach to managed care in which public health entities collaborate to run a "grassroots" disease management program. CHCS has been working with State B to convert the grassroots program into a primary care management program that will offer chronic disease management as an enhanced benefit. The RFP to support this function is expected to be released in early 2005. The program includes a BCAP collaborative as a core component to encourage integration between plans and disease management. State staff believe that they have fundamentally infused quality into the state's approach to Medicaid managed care. They were optimistic that the state's initiatives would continue even with the expected change in state leadership as of November.

State C. Attempting to resuscitate a program in crisis, State C's Medicaid leadership worked with CHCS through the Purchasing Institutes and through follow-up technical assistance to rethink its service delivery model, combining Medicaid and SCHIP into one seamless "Family Coverage" program. To retain plans, CHCS helped State C work with actuaries to develop more attractive rates. State C subsequently participated with CHCS in a Purchasing Institute to develop a template for quality management that, according to staff, was the first strategic plan of its type in the nation to gain approval. State C used the plan to develop the RFP for its External Quality Review Organization, which is reportedly now used as a model for other states. State staff said that "CHCS made a huge difference. . .with our quality measurements." Even though State C has hired a new director since introducing the above changes to its delivery model, it has institutionalized those changes, which still remain in place.

State D. With the support of CHCS, State D worked to revamp what it viewed as a highly regulatory, uncoordinated managed care program. Through Purchasing Institutes, on-site technical assistance, and support from a grant, State D developed a "value-based purchasing strategy" and several tools it viewed as necessary to carry out the strategy. The state also

developed a risk-adjustment system based on encounter data for use in improving its rate setting. It also crafted a set of performance measures, compliance levels, and incentives that it "vetted" with plans and advocates. The tools allow the state to stratify its Medicaid population by diagnosis and cost and to make meaningful comparisons among plans by using risk-adjusted performance measures. Despite a change in program leadership, State D continues on the same path with a director who has moved up the ranks. The state's eroding fiscal climate, however, has meant reduced capitation payments and the loss of funds intended to reward managed care organizations. As an alternative, the state is considering the use of nonmonetary incentives (e.g., reduced burden, favorable publicity) to create rewards. It has also developed a consumer report card and is using a model demonstration grant to develop better risk-adjusted performance measures.

State E. State E's involvement with CHCS began with a model demonstration grant in 1999 that aimed to move the SSI population into managed care.[20] Ultimately, the model failed, but the state, working with CHCS, has recently succeeded in changing the bidding process for its Medicaid managed care program. Encouraged by CHCS, State E worked to incorporate quality-related and fiscal solvency provisions into its RFP for managed care. In addition to improving choice, the state hoped to use the RFP requirements to reduce the number of participating plans. State staff said that the outcome of the procurement reduced the number of plans (from 19 to 16) while reducing the number of counties with only one choice from 13 to five of the state's 89 counties. Despite changes in state leadership, State E remains involved with MMCP and committed to the changes it has introduced. The new state Medicaid director speculates that the

[20] The model demonstration grant was awarded to a quasi-public organization that the state asked to apply for the grant to examine research-based programs that reduce secondary conditions in SSI members.

managed care system would have been dismantled had the state not improved its rate-setting practices in FY 2005.

State F. State F's program is based around a primary care case management model. The state wanted to emphasize collaborations with physicians as a means of improving quality and, to that end, worked with CHCS via a Purchasing Institute, on-site technical assistance, a model demonstration grant, and BCAP. The most general effort involved the development of a model and implementation plan for a physician incentive plan; budget constraints have delayed execution. The state was more successful in using grant funds to develop specialized managed care programs geared to disabled and special needs children in two communities. Both programs are now in place. The first involves catastrophic case management and family-specific care and has been expanded to four counties; the second participated in BCAP 4 and thus developed a redesigned case management system. Now in operation in three counties even though the grant has expired, the system coordinates care across a multiplicity of agencies and includes resource materials such as "All about My Child," which is a parent notebook that assists parents in maintaining a portable medical record.

State G. Given the decline in its participating plans and provider resistance to risk-based models, State G was motivated by a desire to create a managed care program that was other than full risk. Working with CHCS, the state developed direction for its strategy by participating in a Purchasing Institute and tapping CHCS' on-site technical assistance. With CHCS' guidance, State G then developed an RFP for a fee-for-service model program that layered case management. The program, entitled (State) Managed Care Enhanced Care Management Program, targets elderly, blind, and disabled Medicaid beneficiaries with chronic conditions such as diabetes and congestive heart failure and is scheduled for phase-in in seven urban and eight rural sites. CMS approved the program in July 2004, with enrollment beginning in September

2004. State G intends to continue working with CHCS during program implementation in order to develop outcome and accountability measures for incorporation into managed care contracting.

State H. State H has been involved with CHCS for a number of years, working through a Purchasing Institute and a model demonstration grant to refine the state's already developed Medicaid managed care program. Under a planning and demonstration grant, State H developed a Medicaid Health Indicators Data Archive that includes state and national trend indicators, utilization guidelines, and cost measures for adults with special needs and children with disabilities. The state uses the system to measure health status, outcomes, and unmet needs. The state director said that the system "built in services that improved our system and allows us to demonstrate outcomes in a way policymakers can understand and appreciate." A one-year grant extension will permit State H to work with CHCS to develop a Medicaid HMO program for its adult population. The state continues to be enthusiastic about its work with CHCS, saying that CHCS perceives it to be a "model state" with the potential to benefit other states and vice versa.

State I. State I has participated with CHCS since the first Purchasing Institute, during which CHCS helped the state develop a model to pool funding sources and systems for the severely developmentally disabled and mentally retarded (DDMR) into a single managed care program. With CHCS assistance, the state has also revised its risk-based contracts to focus on outcomes and performance. Budget difficulties, however, have stalled both initiatives, causing the state to pull back from managed care. The state expects a delay of 3 to 10 years before getting the program back on track. With the support of a CHCS grant, the state did implement a narrower set of information strategies directed at home- and community-based services, one part of which continues, and involves instruments to help educate residents about options for long-term care services.

State J. State J worked with CHCS through four Purchasing Institutes (one as faculty) and a related on-site visit to enhance Medicaid managed care plan performance and improve what the state viewed as a hostile relationship with plans. The state introduced three primary changes involving improved encounter data, reworked performance measures for Early and Periodic Screening, Diagnosis and Treatment (EPSDT), and creation of a budget initiative to expand pharmacy benefits. The state is now making age, race, and gender adjustments to performance measures and is converting the rate setting system to use of the Chronic Illness and Disability Payment Systems. HealthCheck, the state's reward-based payment system for EPSDT, underwent modification to make the system less punitive and to provide graduated rewards, which, according to the state, has led to improved quality as a consequence of screenings, especially for lead, asthma, and diabetes. The state has not implemented the proposed expansion of pharmacy benefits, though it has introduced new cost control measures. Despite a change in state Medicaid leadership, State J intends to continue working with CHCS, with the intent of becoming more aggressive about managed care for the disabled and, ultimately, SSI beneficiaries. Impressed with what it regards as the positive effects of BCAP 5 for two of its health plans, State J has encouraged all of its health plans to use the BCAP typology and framework for their quality improvement work.

3. Discussion of Change and Contributing Factors

Our findings show that as many as half of all states nationwide with some involvement in Medicaid managed care believe that they have made concrete improvements as a result of MMCP, though we could verify concrete accomplishments in only nine states and a 10th that had developed but was unable to implement its initiative. Further, the states appear to have maintained the various changes despite the turnover in many state directors and an eroding state fiscal climate.

It is difficult to judge whether the changes would have been made without CHCS involvement. Certainly, the states examined here received substantial support from CHCS in a variety of ways, including involvement in Purchasing Institutes, on-site technical assistance, and grants. Without a grant, for example, State H said that it would not have had the resources to develop its indicator system. CHCS also provided several states with ideas that helped them form their initiative, such as the idea for the State B's Report Card. Another four of the nine (State A, State F, State G, and State J) states said that while they might have implemented changes without CHCS, they would have done so much more slowly. State experience with MMCP also highlights the importance of the ongoing relationship between states and CHCS. States working closely with CHCS knew and respected the skills of the staff and often had years of continuing contact with them, which helped support change at the state level.

The state-CHCS collaborations that led to change highlight the important role of state leaders in supporting change. Several former state directors and current state directors provided a critical "spark" and influenced the state's activities. If these leaders were able to "institutionalize" change, their individual departures did not undermine the changes they advocated for and supported.

C. SUSTAINABILITY AND REACH OF LONG-TERM CHANGE

While the evaluation of MMCP's work with states to spur more informed purchasing is relatively positive, the examples also highlight the importance of state program leadership, state fiscal conditions, and other factors that create an environment conducive to sustaining long-term change. We present here evaluation findings that shed light on two challenges—the stability of state leadership and reaching beyond currently involved states. The section concludes with a review of what state directors viewed as the challenges in developing responsive and financially sound Medicaid managed care programs.

1. Stability of State Leadership

Changes in leadership of state Medicaid programs are a fact of life, though some directors manage to stay on for years or are appointed by independent commissions that can buffer them from change. Turnover in senior state Medicaid positions has been particularly common in recent years. When we surveyed directors in summer 2003, we limited the survey to directors who had been place since at least November 2002; we wanted to make sure that we were talking to people with sufficient experience to assess MMCP. (In the case of turnover, we interviewed former directors whenever possible.) Over one-quarter of the directors had turned over since November 2003 (13 of the 43 interviewees were former directors or, in the case of large programs, deputies). As one director noted, "That's just the nature of the beast in Medicaid. The average stay of a Medicaid director is only a year and a half. You don't have a lot of Medicaid directors that have been around a long time." In addition to normal turnover, last year saw the loss of several long-time, experienced directors.

To address concerns about generalizing our findings in light of high turnover, we reinterviewed directors in states where such turnover was common (Howell and White 2004). We surveyed 13 of 14 identified directors in summer 2004, including one surveyed before who was not aware of CHCS at that time. The survey included a number of core items from the 2003 survey and elicited additional insight into turnover as an influence on CHCS activity.

The good news is that all the new directors, save one, were aware of CHCS, with most accurately characterizing CHCS' primary objective as serving as a resource to states on Medicaid "best practices," "to help Medicaid programs figure out how to make managed care work for their population," and to "provide objective information for state programs and best practices in Medicaid managed care." As in the earlier survey, directors typically were more aware of CHCS' work with states than with health plans, consumer groups, and so forth. New

directors' views also were relatively similar to those of the previous year's interviewees with respect to their assessments of CHCS and the importance of its activities. As was the case with directors interviewed in 2003, new directors viewed CHCS as an important resource that complemented other sources of information. Nine new directors said, for example, that if CHCS did not exist, its absence would adversely affect them. New directors did not necessarily have the same views as the directors they replaced in the respective states, but a detailed comparison of transition states indicated that, on average, new directors rated CHCS at least as important as did their predecessors. In a few cases, turnover even created opportunities that permitted CHCS to become involved with states that previously expressed less interest in CHCS.

But the interviews also highlighted the challenges that turnover created for CHCS. Among the new state directors, four had limited recent experience with Medicaid at the state level before assuming the director's position, and two had primarily budget rather than program experience with Medicaid before their appointment as state Medicaid director. Only four had experience with managed care. In contrast, most of those interviewed in 2003 had a minimum of two years' experience with managed care.

Though CHCS indicated that it planned to reach out aggressively to the new directors, our interviewees indicated they already were aware of CHCS as a function of their experience working in a Medicaid program or managed care organization, rather than as a result of CHCS' efforts to inform them about the Center and its program.

While CHCS believes that it made overtures to new directors after the 2002 election,[21] our interviews found that the directors viewed such contacts, if they reported them at all, to be very limited:

- As far as they recalled, seven new directors reported that the Center did not reach out to them at all; one director was not sure if he had been contacted.
- Only two state directors reported that the Center actively reached out to them, with one also reporting that state staff reinforced the information provided by the Center.
- Two directors first became aware of the Center through the National Association of State Medicaid Directors' New Directors orientation meeting.

Three directors indicated that they received letters only, but they were already familiar with CHCS through their professional experience before becoming state director. Two directors first learned of the Center through the MPR interviews, one this year and one last year.

Further, only four of the 14 new state directors attended the Purchasing Institute in Colorado Springs in November 2003. A fifth planned to attend but ultimately did not participate because of a conflicting commitment, though he sent four staff members (the state has a long history of attending the Purchasing Institute).[22] Of the other nine directors, three said no one from their state attended because they were not aware of it. Competing time demands prevented two other states from attending; a budget crisis kept one state away; and constraints in the travel budget, coupled with staffing issues and a lack of strong interest in the topics covered at the institute, kept away one other state that had participated in other institutes. Of the other two, one participated in previous institutes but did not find the topics covered in Colorado of interest, and

[21] CHCS told us that, in 2003, it intended to reach out actively to new directors through Medicaid leadership programs such as the National Association of State Medicaid Directors and that it planned to use the 2004 Purchasing Institute as a vehicle to begin engaging new Medicaid directors in center activities.

[22] Among new directors in attendance, one was a former staffer in the program with substantial CHCS history, and another learned of the program through MPR's earlier 2003 interview.

another was philosophically opposed to managed care and saw CHCS as a managed care advocate.

Though some assume that existing state staff would have briefed the state directors about CHCS, just under half the interviewees said that staff provided them with information about CHCS and the state's involvement with its various programs. In nine states, much of the senior leadership in the Medicaid program also changed with the new director, and the new staff were unfamiliar with CHCS. Thus, state directors cannot necessarily rely on staff as a consistent source of information about CHCS. If new directors and senior staff are to be informed about the Center and its programs, CHCS will have to undertake a more aggressive outreach effort.

These findings suggest that CHCS needs to be more proactive in reaching out to new directors, both to inform them of MMCP capabilities and programs and to determine state director–specific needs that MMCP could address. All but one director indicated that a telephone call from CHCS would be the most effective way both to introduce CHCS to staff and to describe its current programs. Many also suggested that an orientation package describing MMCP's programs would be very helpful. Four directors, including two whose states currently have little involvement in MMCP programs, indicated that a visit from a CHCS staff member would be highly desirable and that such a visit would provide an opportunity for CHCS to meet, first, with the director and, second, with a group of key senior staff. All directors commented that, given the volume of incoming mail, letters from CHCS are the least effective way to capture their attention; they similarly agreed that, given email volumes, an email letter is not much better. Howell and White (2004) outline specific recommendations about how CHCS might proceed should it wish to pursue these outreach suggestions.

In sum, MMCP operates in an environment in which turnover is common among high-level and sometimes senior staff in Medicaid managed care programs. To reduce the effects of

turnover, directors surveyed in 2003 called for (1) helping states develop strategies and action plans important enough to withstand leadership changes, (2) emphasizing the long-term nature of initiatives and the need for a commensurate commitment, and (3) working to help bridge the inevitable transitions. Active outreach to new leadership could include meetings with the health policy staff of incoming state administrations, providing information on an ongoing basis, continuing to work with teams that include Medicaid staff at all levels, and, even, as one director recommended, developing a training package for Medicaid directors on "how to survive."

2. Reaching beyond Current States to Others

In contrast to the commercial sector, risk-based managed care remains common in Medicaid, though fewer plans participate and an increasing share of them are Medicaid-dominant (Draper, Hurley, and Short 2004). What do we know, then, about whom MMCP has reached? What is the potential to reach further? We address these questions by, first, reviewing what is known about the general trend among states to improve value-based purchasing and quality of care in Medicaid managed care and, second, analyzing MMCP's reach in light of those and other data.

Overall Trends in State Purchasing of Medicaid Managed Care. In assessing the value of MMCP's work with states on Medicaid managed care, it is useful to understand the general direction of state activity in support of quality improvement, even if MMCP is only one of potentially a number of influences shaping quality improvement activities. Fortunately, a series of surveys of states over the 1995–2001 period (not conducted by us) provides just such data (Landon et al 2004). The surveys, carried out by researchers at Harvard University with funding from the Robert Wood Johnson Foundation, queried state Medicaid agencies involved in Medicaid managed care on the characteristics of their programs and how they were addressing a

number of issues related to quality improvement. Relatively consistent state data are available for 1995, 1998, and 2001.

The findings from the surveys provide strong evidence that, over the survey period, states pursuing risk-based managed care (the only states included in the survey) increased their reliance on what has been characterized as "value-based purchasing." Despite the continuing need for substantial improvement in the characteristics of their purchasing, the surveyed states were increasingly likely to collect data on satisfaction, access, and quality; to make such data available to plans (and to a lesser extent to enrollees); and to develop targeted quality improvement programs linked to these measures, in some cases demonstrating improvements (see Table IV.2).

Progress across various aspects of value-based purchasing has been uneven. For example, efforts aimed at measuring and improving satisfaction with care are substantially more developed than efforts related to improving and measuring access and quality. In the quality area, efforts focused on childhood immunizations are more developed than work addressing other quality-related topics. Performance monitoring relative to mental health/substance abuse tends to be substantially less developed than that focused on medical care (data not shown), perhaps in part because of the complexities associated with developing effective managed care arrangements in this area which has multiple programs and funding streams (Gold and Mittler 2000; Frank, Goldman, and Hogan 2003). Historically, states have made little use of financial incentives to encourage quality in Medicaid managed care, but the number of states doing so increased from three to 12 between 1999 and 2001 (Landon et al 2004).

Further, state reports of use of a technique do not necessarily mean that the technique is well developed or conceived. For example, some states working with CHCS have decided to move away from a regulatory approach to quality and toward a more collaborative approach. These states might therefore appear active in that they collect several types of data (some not well

TABLE IV.2

MANAGED CARE PERFORMANCE ACTIVITIES BY STATE MEDICAID AGENCIES, 1995, 1998, 2000
(percentage of states)

	Data Collection			Provided Information to Plans			Provided Information to Enrollees			Targeted Quality Improvement Program			Demonstrated Improvements		
	1995	1998	2001	1995	1998	2001	1995	1998	2001	1995	1998	2001	1995	1995	2001
Satisfaction with Care	63	69	89	37	67	84	20	13	37	43	44	61	13	22	35
Access															
Translators	17	40	50	0	24	37	27	18	13	10	20	21	7	13	15
Kept waiting in office	--	42	47	0	27	50	3	2	18	--	18	37	--	9	18
Quality															
Early prenatal care	59	73	82	8	53	66	3	2	11	53	62	67	10	29	47
Cervical cancer screening	47	53	63	6	44	53	10	7	13	33	47	37	3	22	26
Diabetes glycohemoglobin	23	24	58	5	24	47	3	2	8	17	29	58	0	13	39
Check immunization	83	89	84	9	69	76	17	11	13	67	67	76	20	35	58
Appropriate medications for asthma	--	--	50	--	--	45	--	--	11	--	--	63	--	--	42

SOURCE: Landon, Schneider, Tobiaso, Epstein in *Health Affairs*, July–August 2004.

NOTE: Includes states with full risk-based plans in Medicaid Managed Care. N = 30 in 1995; 45 in 1998; 39 in 2001. All eligible plans responded except in 2001, when only 38 responded.

-- = Not asked

used) or impose penalties on plans; at the same time, their strategies may be weak and in need of improvement.

Characteristics of States Reached by MMCP. For much of its history, MMCP has faced conflicts about the definition of its target audience(s). Early on, CHCS introduced "readiness assessments" out of concern that states needed a certain amount of capacity, or "readiness," to pursue complex initiatives such as Medicaid managed care. CHCS often thinks of itself as working with "leading states" capable of implement "cutting-edge" strategies that will diffuse to other states. But, in point of fact, many of CHCS' state programs (such as the Purchasing Institutes) appear to have targeted states with both moderate and high levels of sophistication. An understandable desire to be responsive also has sometimes led to inclusion of states with limited experience (for example, Mississippi) just because needs are great and there is the potential for cross-learning. Further, in recognizing the importance of state leadership, CHCS has worked extensively with less experienced states to capitalize on opportunities to respond to the interest and commitment of new state leadership.

Who then has MMCP reached in its current work? To provide insight into this question, we developed two separate measures of state sophistication, one based on "knowledgeable experts" and the other based on state-conducted activities as reported by states in the 2001 Harvard survey.

Measures Used. We based the first measure on sophistication ratings of each state as compiled by two experts in the field of Medicaid managed care.[23] The experts assigned each state a rating of high, moderate, limited, or none by using the following guidance:

[23] We attempted to have a third person rate states as well, but the individual was not able to complete the task in the required time frame.

- High: Program and staff have "pushed the envelope" in developing techniques for prudent purchasing
- Moderate: Program and staff have tried some things that go beyond the ordinary, but their sophistication and/or what the environment will support is mixed
- Limited: Staff are oriented toward the basics (e.g., signing a contract with required terms and program elements) and not much more than that
- None: Staff do not know about managed care and the state's experience with it is extremely limited or nonexistent

We derived the second measure of state sophistication from multiple variables in a survey of state Medicaid agencies conducted by Harvard researchers in 2002.[24] Specifically, we developed four categories of states based on the following measures:

- High sophistication: States that have a pay-for-performance initiative, required NCQA accreditation, and/or provided risk-adjusted capitation payments to plans and had nine or more activities related to data collection, feedback to plans, and quality improvement projects
- Medium sophistication: States that had eight activities related to data collection, feedback to plans, and quality improvement projects as well as states that had nine or more activities in these areas but did not engage in pay-for-performance, NCQA accreditation requirements, or risk-adjusted capitation payments
- Low sophistication: States that did not engage in any pay-for-performance initiatives, did not require NCQA accreditation, did not risk-adjust their capitation payments to plans, and had seven or fewer activities related to data collection, feedback to plans, and quality improvement projects
- PCCM only: States that had no comprehensive prepaid managed care arrangement under Medicaid (and therefore were not in the sample frame for the Epstein et al. survey) but rather only primary care case management. Note that Alaska and Wyoming are not included here because they have no primary care case management or Medicaid managed care arrangement of any type.

[24] We also developed another, more complex measure of state sophistication based on the Harvard data using a 100-point scale. However, we focus only on the categorical measure presented above because it is more easily understood and more interpretable. Note that the correlation between the two measures developed from the Harvard data was fairly high (0.76).

The second measure of sophistication is more objective than the first, but it focuses on state activities, not necessarily on more intangible factors that define how well or appropriately states are intervening for their marketplace, something that the "experts" presumably can assess. However, our "expert" measure is limited by the small number of raters and the relatively limited formal criteria we provided to them for assessment.[25] To assess the potential relationship between program maturity and length of experience, we also examined the association between years of state Medicaid managed care experience and both sophistication measures. Despite some association, states operating some type of Medicaid managed care for many years are not necessarily more sophisticated than their less experienced counterparts.[26]

Relationship between Sophistication and Participation Levels. Table IV.3 shows, for each sophistication level, the percent of states that participated in CHCS activities. For both sophistication measures, we observe a clear relationship between participation rates and sophistication levels, with more sophisticated states more likely to participate in one or more CHCS activities. The same general relationship holds in the examination of intensity of participation—with more sophisticated states engaging in a larger number of CHCS activities—though the relationship is less linear for the categorical ratings of state sophistication based on the Harvard data as compared with the expert ratings.

[25] Analysis shows that the two measures have a fair level of correspondence, with between the expert ratings of states and the categorical ratings of states based on the Harvard data. The correlation between these measures is about 0.50. The two types of sophistication measures produced ratings within one "level" of one another for nearly 90 percent of states.

[26] We placed states into one of three categories of maturity: 0 to 10 years (reflecting states that are new to Medicaid managed care), 11 to 20 years (reflecting states with somewhat more experience), and 21 years or more (reflecting states that have had programs in place since the start of Medicaid managed care in the early 1980s). While states of greater maturity tend to be those with higher levels of sophistication, this relationship is not statistically significant (though the detection of a relationship is difficult with only 48 states).

TABLE IV.3

PERCENT WITH ANY PARTICIPATION IN CHCS ACTIVITIES BY LEVEL OF SOPHISTICATION OF STATE'S MEDICAID MANAGED CARE PROGRAM

Level of Sophistication of State Medicaid Managed Care Program	Percent of States that Participated in Any CHCS Activity (Purchasing Institutes, technical assistance, or grants)[a]
All states (n=49)[c]	76%
Expert Ratings of Sophistication	
High (n=6)	100%
Moderate (n=23)	87%
Limited (n=16)	63%
None (n=4)	25%
Categorical Rating of Sophistication Based on Harvard Data	
High (n= 17)	94%
Moderate (n=15)	80%
Limited (n=6)	67%
PCCM only (n=10)	50%

[a]Source of information for participation and number of activities is CHCS administrative data.

[b]Among states that participated in any CHCS activities, the figure represents the sum of the number of Purchasing Institutes, the number of technical assistance experiences, and the number of grants, averaged among all states in a given category.

[c]Total of 49 states includes the District of Columbia and excludes Alaska and Wyoming (because they have no Medicaid managed care programs). Note that the number of states with Epstein categorical ratings sum only to 48 states, given that Nebraska did not complete the survey.

We also examined state participation in specific CHCS activities. As shown in Table IV.4, CHCS awarded grants to states with varying levels of sophistication. The 34 states that participated in Purchasing Institutes tended to be more sophisticated states, with the large share falling into the highly to moderately sophisticated categories. Similarly, states that participated in CHCS technical assistance activities included a range of sophistication levels but also tended to be more sophisticated.

TABLE IV.4

PARTICIPATION IN SPECIFIC CHCS ACTIVITIES BY LEVEL OF SOPHISTICATION OF STATES' MEDICAID MANAGED CARE PROGRAM

Level of Sophistication of State Medicaid Managed Care Program	States Receiving Grants* (column percent)	States Participating in Any Purchasing Institutes (column percent)	States Participating in Multiple Purchasing Institutes (column percent)	States Participating in Technical Assistance Activities (column percent)
Total Number of States	13	34	19	18
Expert Ratings of Sophistication				
High	1 (8%)	6 (18%)	4 (21%)	3 (17%)
Moderate	7 (54%)	19 (56%)	9 (47%)	10 (56%)
Limited	5 (38%)	8 (24%)	5 (26%)	5 (28%)
None	--	1 (3%)	1 (5%)	--
Categorical Ratings of Sophistication Based on Harvard Data				
High	7 (54%)	15 (44%)	10 (53%)	6 (33%)
Moderate	2 (15%)	12 (35%)	4 (21%)	8 (44%)
Limited	1 (8%)	4 (12%)	2 (11%)	2 (11%)
PCCM only	3 (23%)	3 (9%)	3 (16%)	2 (11%)

*Note that four states received multiple grants.

Participation in CHCS did not vary systematically with the age or maturity of state Medicaid managed care programs. As shown in Table IV.5, states with older Medicaid managed care programs did not exhibit higher rates of participation in CHCS but had been involved in a higher number of activities.

Relationship between Sophistication and Outcomes. We also examined several outcome variables with respect to state sophistication levels. First, we investigated whether states whose Medicaid directors reported participation in one or more Purchasing Institutes (n=23) also reported making specific change as a result of that participation. While 65 percent of states

TABLE IV.5

PERCENT OF STATES WITH ANY PARTICIPATION IN CHCS ACTIVITIES BY MATURITY OF STATE MEDICAID MANAGED CARE PROGRAM

Maturity of State Medicaid managed care program[a]	Percent of states that participated in any CHCS activity[b]	Average number of activities among states that participated
0 to 10 years (n=13)	77%	2.5
11 to 20 years (n=20)	75%	2.8
21+ years (n=16)	75%	3.3

[a] Source: National Academy for State Health Policy (1996; 2001)

[b] Source: Evaluation of CHCS' Medicaid Managed Care Program: Results from Surveys of State Medicaid Directors and Senior Program Staff

reported their participation, the relationship did not appear to be systematic by level of sophistication (see Table IV.6); however, participants represented a relatively small number of states, making detection of differences difficult. We also examined the sophistication level of the 10 states with concrete changes resulting from CHCS activity (see earlier discussion in this chapter)—based on evidence of concrete changes made after participation in CHCS activities—and found that these states ranged from high to limited sophistication.

States' Assessment of CHCS. We also examined how states' assessment of CHCS varied by state sophistication level. Although based on a particularly small sample of states that participated in Purchasing Institutes, states' overall ratings of the Purchasing Institutes tended to be higher among less sophisticated states. Of the 15 states that gave the Purchasing Institute an excellent rating, seven demonstrated limited sophistication, according to expert ratings. Among the seven states that gave the Purchasing Institutes good or fair ratings, five were moderately

TABLE IV.6

OUTCOMES BY LEVEL OF SOPHISTICATION OF STATES' MEDICAID MANAGED CARE PROGRAM

Level of Sophistication of State Medicaid Managed Care Program	Purchasing Institute Participants Reporting Change as a Result of Purchasing Institute (n=15) (column percent)	States with Concrete Changes as a Result of CHCS Activities* (n=11) (column percent)
Expert Ratings of Sophistication		
High	20%	27%
Moderate	27	46
Limited	53	27
None	--	--
Categorical Ratings of Sophistication Based on Harvard Data		
High	33%	55%
Moderate	40	27
Limited	13	18
PCCM only	13	--

*Medicaid directors from 11 states indicated that the state had received technical assistance from CHCS. Ten of 11 states reported making changes as a result of the receipt of technical assistance; the 1 state that did not report changes demonstrates a moderate/medium level of sophistication according to both sophistication measures.

sophisticated and one was highly sophisticated. When asked if they could obtain from other sources the same types of assistance provided by CHCS, just over half of state Medicaid directors agreed that they could. There was no relationship between this question and the level of state sophistication, however. Similarly, in a response that bore no relationship to the level of state sophistication, slightly over half of the Medicaid directors indicated that CHCS could be more effective in its approach. Finally, state directors' assessment of CHCS' importance in strengthening the Medicaid managed care program did not vary by state sophistication; overall,

about 19 percent of state directors said that CHCS was extremely helpful, and another 61 percent indicated that CHCS was very or somewhat helpful.

Implications. Logic suggests that MMCP is more likely to achieve success if it targets states most likely to succeed. However, our analysis shows that, with the exception of the least sophisticated states, which tend to participate less, state participation in MMCP varies substantially across sophistication levels. Further, states that have made changes in response to their MMCP participation span a spectrum of sophistication levels. Obviously, assessing state sophistication is challenging, and our measures are inevitably limited. We believe, however, that the results of the analysis indicate, first, that MMCP has the potential to be helpful to many states and, second, that, given our criteria, it would be difficult to define upfront which states are most likely to succeed. At times, the types of opportunistic strategies used by MMCP appear appropriate. In a climate of limited resources, additional research could be valuable to clarify who best can take advantage of the assistance offered by MMCP, thereby making the most productive use of available assistance.

D. STATE PERCEPTIONS OF THE ENVIRONMENT

In 2003, Medicaid directors queried about the major challenges they saw in improving the purchasing of Medicaid managed care cited five barriers to improvement. By frequency of mention, the factor were:

- Ability to attract and maintain plan participation
- State economic climate
- Low capitation rates/provider resistance (tie)
- Federal requirements

As one state director observed, “I’ve seen our environment growing less competitive with plans; a few years ago, we had six quality health plans and now we have three.” Attracting and

maintaining sufficient participation by plans poses a major challenge in states with large rural areas. As one director in a large rural state remarked, "In our state, it's a demographic issue. We have managed care in two city areas, and we've never been able to take it beyond these areas." Based on responses to questions asking them to rate several factors listed in terms of whether they were major barriers, minor barriers, or not barriers at all, senior program staff appear to perceive that the improvement of Medicaid managed care faces several obstacles (see Figure IV.1). Asked to rate specific potential challenges, staff noted that, among the top challenges facing Medicaid managed care, are inadequate state staffing and insufficient state funds to procure needed assistance. Ironically, in interviews with state directors, staff limitations also appear to limit states' ability to tap into available resources such as CHCS. As one director lamented, "[T]he number of people we have available to work with a place like the Center on a project is limited right now due to layoffs and early retirements." Travel restrictions are another barrier, although several other directors said that when an outside organization pays for travel, state-imposed restrictions cease to be an issue.

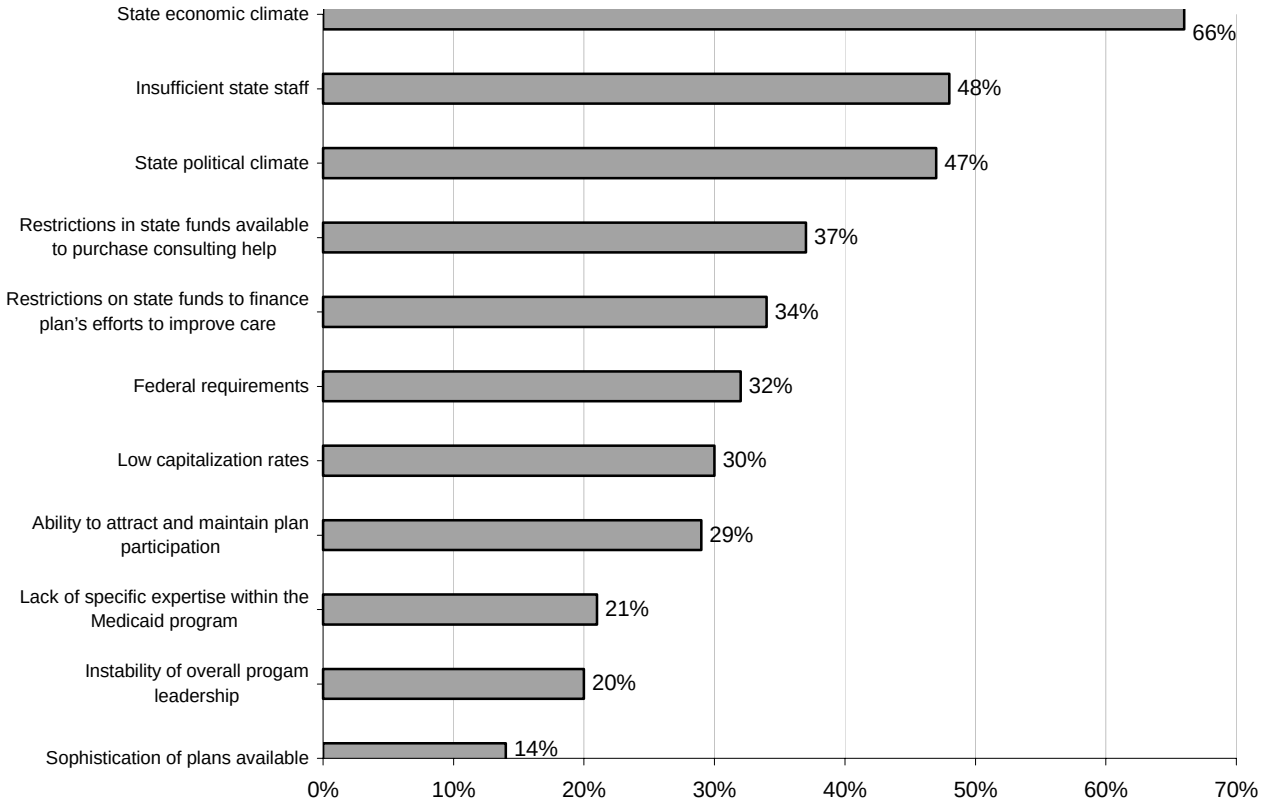
E. SUMMARY OF FINDINGS

This chapter is the first of three that address what for many is a key question about MMCP—does the program make a difference, especially in tangible ways that ultimately affect the people served by Medicaid managed care. In this chapter, we summarized the findings about whether MMCP has helped states—a key audience for MMCP—develop into better purchasers, thereby generating sustainable changes.

The findings are encouraging. Half of all Medicaid program directors said that they made concrete improvements in their Medicaid managed care program as a result of their participation in MMCP. To an extent, the changes reflect intangibles that are hard to prove, such as validating

FIGURE IV.1

PERCENTAGE OF SENIOR PROGRAM STAFF INDICATING FACTORS WERE A "MAJOR BARRIER" TO IMPROVING STATE MEDICAID MANAGED CARE PROGRAMS



Source: MPR survey of senior Medicaid programs staff 2003.

Note: The other/choices were "minor barrier" and "not a barrier".

state activities, ideas, and support. But we also found evidence in the information available to us that at least 10 states made substantive improvements in their Medicaid managed care programs as a result of MMCP, all but one of which was implemented and remained in place as of fall 2004. Generating these improvements required an investment by MMCP—each state participated in at least one Purchasing Institute, six received on-site technical assistance, and eight received grants, including five states awarded the largest type of MMCP grant (model demonstration grant).

States made these substantive changes despite extensive staff turnover and budget pressures. The support of a strong state director appears important to success. In fact, if state directors can stay long enough to implement changes, such changes are likely to become institutionalized as part of the fabric of state Medicaid programs. Our analysis of turnover in 2003–2004 shows that MMCP maintained the support of directors despite turnover but that such support was more the product of chance than the result of active work by program staff. Given that turnover in state leadership is an essential feature of the Medicaid environment, CHCS must become more proactive in reaching out to new leaders as turnover occurs.

Taking advantage of existing studies on trends in state Medicaid managed care purchasing, we also find that states have become more sophisticated purchasers since MMCP's inception. While MMCP should not be credited with causing greater purchasing sophistication on the part of states (many influences were at work), trend data do show that MMCP is working in a changing, increasingly sophisticated environment.

In this chapter, we sought to profile the sophistication of states reached by MMCP and what various levels of sophistication might imply about the program's future reach. The findings provide strong evidence that MMCP now reaches states with at least moderate sophistication in Medicaid managed care and risk-based strategies, more so than states with more limited programs, which is as MMCP planned to do. We also, found, however that among states with at least a moderate level of sophistication, the best performers in the program (i.e., those that introduce changes) span a spectrum of sophistication levels, suggesting that MMCP has the potential to be helpful to a variety of states and that opportunistic targeting, such as CHCS employs, can have merit. Nonetheless, given resource limitations, additional work would be valuable to learn more about who best can benefit from MMCP.

Finally, the findings highlight the ongoing challenges faced by states attempting to improve their Medicaid managed care programs. As state directors see it, the most critical challenges are attracting and maintaining plan participation, the erosion of the state fiscal climate, low capitation rates/provider resistance, and federal requirements. The economic and budgetary climate is likely to remain a pervasive influence in the future, affecting plan participation and rate setting. Particularly as the federal government considers how to respond to the deficit and the fiscal pressures it faces, such a climate can create challenges for states seeking to improve care, but it can also reinforce the need for value and value-based purchasing.

V. HAS MMCP HELPED PLANS IMPROVE QUALITY IN TARGETED AREAS, AND WILL CHANGE ENDURE?

A. IMPORTANCE AND METHODS OF ASSESSMENT

In addition to states, MMCP's other main audience was health plans. Starting in 2000, MMCP invested heavily in and worked closely with plans; MMCP's goal was to improve managed care practices and quality in Medicaid managed care. As with states, our evaluation of MMCP's success in achieving its goals is based on feedback from a survey of the audience, in-depth interviews with those most intensively involved with MMCP, and other available information.

In the case of health plans, the in-depth look at accomplishments required interviews with staff from each of the plans participating in four of five CHCS BCAP workgroups conducted between 2000 and 2004. The interviews took place well after the workgroups had completed their activities so that we could learn what the BCAPs accomplished and whether those accomplishments were sustained. While we originally planned to include only the first three BCAPs, we added the fifth because it was one of two that focused on small subgroups of particularly vulnerable chronically ill individuals (in this case, care for adults with chronic illnesses and disabilities). It thus provided a useful contrast to the other three, which focused, respectively, on birth outcomes, preventive care for children, and asthma.

Our methods have their strengths and limitations. Given that the interviews included all participants in the workgroups, they provide an especially useful way of judging not just the plans' various accomplishments but also what share of participants succeeded and why some participants were more successful than others. Though we reviewed documents and made every effort to confirm what plans reported, our findings rely mainly on self-reports without independent validation. In addition, CHCS staff acknowledge that the limitations in data

development needed to capture whether plans made improvements is a weakness, though having and using such data is core to such rapid cycle feedback methods as BCAP. CHCS has hired staff and developed methods to create more consistent measures to support BCAP, but the measures generally were not in place for any of the BCAPs conducted to date under MMCP auspices, though they are expected to be in the future.[27] The development of appropriate measurement demands attention to ensure the meaningfulness of future BCAP assessments.

B. EXTENT, NATURE, AND SUSTAINABILITY OF CHANGE

We first describe what plans responding to the survey said about how their involvement with CHCS motivated change in the way they deliver care. We then outline what we learned from our case studies of particular BCAPs.

1. Overall Plan Reports

In total, 27 percent of plans responding to our survey participated in either a BCAP workgroup or workshop, with an additional 3 percent reached through the Quality Summit. The toolkits and other publications reached an additional 16 percent of responding plans and represented the plans' sole means of interaction with CHCS. In the survey, 95 percent of plans participating in the workgroups and 80 percent of plans participating in the less intensive workshops said that they either had made or were considering changes in their plan as a result of their participation.[28] Plan feedback from the Quality Summit was likewise positive (e.g., 88 percent of participants said that the summit left them more informed, and 81 percent said that the

[27] As described in White and Gold (2004), the revised methods first were used in the BCAP collaborative funded by, respectively, CHCF and CMWF. Staff say they aimed to apply them retrospectively to BCAP 5 (which is included here) though we were not aware of such actions from information available to the evaluation.

[28] The statistics include only those plans that reported participating in BCAPs and whose participation could be validated by administrative records. If all who reported attendance at such activities are included, the analogous statistics are 89 and 83 percent. As we discussed earlier, plans had difficulty in distinguishing among workshops, workgroups, and the Quality Summit. In addition, some had participated in similar activities sponsored by CHCS but funded by others.

summit equipped them with new skills). Sixty-three percent (10 plans) said that they had made specific changes as a result of their participation in the summit, including implementation of new approaches for reimbursing asthma services, the addition of asthma case management, computing return on investment calculations for the plan's prenatal program, increased lead testing and, more generally, improved methodology and analysis of quality projects and increased and targeted outreach to members and providers.

The findings show a relationship between the intensity of the activity and the likelihood that plans said that participation spurred them to make a change. In the case of toolkits, for example, the least intensive activity if used without other support, 41 percent of plans familiar with the kits rated them as very useful for providing information, but only 25 percent said the same about the kits' usefulness in identifying specific changes and 19 percent about their usefulness in making specific changes.

2. Change as a Result of Participation in BCAP Workgroups

After a description of the general structure employed in BCAP, we review the experience of the selected workgroups, followed by a general discussion of the key findings across the groups. The contributing reports provide additional detail on each workgroup process (Mittler, Krissik, Gold, and Humensky 2004).

Overview of BCAP Workgroup Structure. Table V.1 profiles the content, time frame, and plan participation in each of the four BCAPs examined in depth. In Phase 1, each workgroup convened three times over a nine-month period to develop, pilot, and refine best practices in the area addressed by the workgroup (see Mittler and Krissik 2004 for additional detail). Phase 2 was a year-long "tail" of telephone follow-up. For BCAP 5 (and BCAP 4, which is not reviewed here), the first phase was extended to a year to accommodate an additional meeting that was needed to identify changes in a particularly complex area. Ideally, we wanted

TABLE V.1

BCAP CASE STUDY TOPIC, SIZE, AND TIME FRAME

	Focus	Health Plans Completing/ Initially Participating	Plan Mix**	Phase 1 (end date)	Phase 2 (end date)	MPR Interviews	Plans Interviewed/ Number of Interviews
BCAP 1*	Toward Improving Birth Outcomes	11/12	8 MD, 2 C, 1 PPCM	12/2000	12/2001	6/2003	10/17
BCAP 2	Improving Preventive Care for Children	11/11	10 MD, 1 C	6/2001	6/2002	6/2003	8/12
BCAP 3	Achieving Better Care for Asthma	11/11	9 MD, 2 C	12/2001	12/2002	7/2003	11/21
BCAP 5	Improving Care for Adults with Chronic Illnesses and Disabilities	12/12	7MD, 1 PCCM, 4 Other	4/2003	4/2004	7/2004	12/22

*A case study of the first BCAP also was developed for MPR's original short-term assessment of MMCP. It included interviews with plans in spring 2001 just after completion of Phase 1. At that stage, plans were still implementing activities but had little, if any, data on change.

** MD= Medicaid-dominant; C=commercial, PCCM=primary care case management, Other=nontraditional models, including three Medicaid-based care management organizations and a county-organized health system

to interview plans a year after each BCAP ended so we could learn about sustainability and general impact. Given the timing of the evaluation, more time elapsed between the end of the BCAP and our interviews for earlier than later BCAPs, with the BCAP 5 interviews conducted only about three months after the end of workgroup activities. Readers may want to keep these facts in mind while considering the case study results.

Participating plans varied, but each was required to have a minimum of 20,000 Medicaid members. While a few commercial plans participated, most plans were Medicaid-dominant organizations. Participants generally were licensed HMOs. Medicaid-dominant plans included

diverse organizations such as traditional safety net plans, many based around community health centers; provider-sponsored organizations; and for-profit plans affiliated with national firms that focus on Medicaid. A few primary care case management models participated in the workgroups. Given the workgroup's focus, BCAP 5 also included "nontraditional plans" that often were not affiliated with a licensed HMO, and, CHCS waived its minimum size requirement, which resulted in participation by three particularly small entities (under 1,000 enrollees) specializing in care for adults with chronic illnesses and disabilities. For simplicity, we use the term "plan" in referring to all BCAP participants.

Participants in BCAP use a framework, referred to as the "typology," to guide project development and assessment (see Table V.2). The typology consists of four categories: identification, stratification, outreach, and intervention. For each category, health plans are required to define aims, measures, and changes, thereby making outcome measures (originally a fifth category of the typology at the beginning of the first BCAP) a part of each category. BCAP emphasizes the "rapid-cycle change" process, in which plans assess aims, measures, and changes often and repeatedly to learn which changes are working and which are not. Over the course of a workgroup, each health plan develops, implements, and measures clinical and administrative practices in each category of the typology. For BCAP 5, plans asked to modify the typology by adding to the framework a first step needs assessment. Given that BCAP addresses the complexity of patient needs, plans perceived that they needed additional time to define the problem before proceeding with quality improvements.

TABLE V.2

SELECTED EXAMPLES OF PLANS' USE OF THE BCAP TYPOLOGY FRAMEWORK

Identification (BCAP 1)

Aim: Increase identification of pregnant women by 25 percent.
Measure: Number of pregnant women known to the plan before delivery/number of pregnancy delivery claims.
Changes: Analyze state claims data for pregnancy codes, provide incentives to physician office managers ($25) to notify plan of pregnancies, and analyze pharmacy data for prenatal vitamin prescriptions.

Stratification (BCAP 3)

Aim: Stratify 100 percent of members with asthma, age 2 through 18, based on pharmacy and utilization data into categories of low, medium, and high risk of future utilization.
Measure: Number of members age 2 through 18 with asthma, stratified into the three categories/number of members with asthma.
Changes: Develop an asthma registry by using pharmacy data, medical claims, and provider and member databases; stratify by using developed criteria (emergency department visits, asthma diagnoses, beta-agonist prescriptions).

Outreach (BCAP 1)

Aim: Contact 50 percent of high-risk pregnant members by telephone or mail to increase the number of women who keep postpartum appointments.
Measure: Number of women reminded to keep postpartum visit/number of women who delivered; number of women who kept postpartum visits/number of women reminded to keep postpartum visits.
Changes: Member services contacts new mothers before delivery discharge to facilitate postpartum visits. Member services collects contact information and informs members about the incentive to keep the postpartum visit.

Intervention (BCAP 2)

Overall Aim: By July 2002, reduce by 50 percent the number of newborns receiving no preventive services by 15 months of age.
Intervention Aim: Provide two Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits to 100 percent of high-risk infants by the fifth month of life.
Measure: Number of high-risk infants with two EPSDT service claims received by the fifth month of life/ total number of high-risk infants included in the health plan's study population.
Changes: Case managers gather risk factor information from prenatal providers to classify expectant mothers' risk of delivering a high-risk infant and to identify those at risk of not receiving an EPSDT visit. All expectant mothers are mailed a maternity packet encouraging selection of a primary care provider for their newborn, and case managers contact members who have not selected a primary care physician at eight weeks before expected delivery. Case managers log and track whether all infants receive EPSDT services by the fifth month of life.

a. BCAP 1: Improving Birth Outcomes

Eleven plans participated in BCAP 1, though one no longer served Medicaid at the time of our interviews (Mittler 2004). At the time of our interviews (18 months after completion of BCAP 1), eight of the 11 original plans completing the workgroup activities were maintaining the changes they had implemented in response to BCAP 1.[29] While three of the eight appeared mainly to be maintaining what they had developed, five appeared to be thriving and continued the evolution of their changes, thereby providing insight into what "success" meant for BCAP 1 in terms of care delivery:

- Plan A established an information hot-line, member incentives to report pregnancies and to complete postpartum visits, incentives for health risk assessment, and a clinical outreach department. Identified pregnancies doubled, and visit compliance increased by about 10 percent between 2001 and 2002. Incentive programs were extended into mammography and dental care.
- Plan B extended its existing efforts to identify pregnant members to members in its entire service area; it continues to screen prenatal vitamin data and pay physicians $25 for notifying the plan of new pregnancies. The identification rate is now 75 percent versus the earlier 3 percent. The plan attempted but ultimately discontinued evening outreach calls and visits to high-volume OB providers because the plan believed the calls were not cost-effective. Original efforts to develop a resource guide for providers were dropped because providers found it was not user-friendly. Instead, the plan now provides resource help to providers directly.
- Plan C screens prenatal data, uses a new risk assessment tool to conduct outreach, and has implemented new protocols to coordinate information and case management across departments. The share of members with completed risk assessments increased by 41 percent from July to October 2000. The plan has begun working with the state to facilitate earlier notification of pregnant enrollees.
- Plan D makes visits to high-volume providers to encourage them to identify pregnant women and perform a formal review of prenatal registration forms to identify and coordinate needed care. Plan D provided cell phones to pregnant members but had to discontinue the practice when grant funding was terminated. The plan piloted a smoking cessation program for pregnant members but discontinued it after finding that reliance on counselors from outside the community undermined member buy-in.

[29] The other three included one that had implemented all its planned activities and was expanding efforts until it withdrew from the Medicaid market; another had implemented some activities by the end of BCAP but shifted to other clinical areas thereafter; and a third that no longer had anyone on board who was familiar with BCAP.

> The plan has received a new grant to implement peer counseling through community health centers; counseling extends to smoking cessation. The plan also now dedicates one case manager to follow up high-risk pregnant members for two years.

Plans that made changes but have generated less long-term success generally attempted activities similar to those described above. For example, turnover in medical leadership and precarious plan finances as a result of the managed care backlash caused one plan to reduce its activities. Another plan working toward change abandoned its efforts when the medical director left and the plan dropped out of Medicaid. (The director said that he continues to use the BCAP framework to examine congestive heart failure in his new location.)

A few plans saw little progress. For example, one plan introduced a risk assessment screening tool but was unable to improve identification via encounter data screening because of poor-quality data. The same plan also dropped several other initiatives after a brief start. Staff turnover and a complex organizational environment impeded plan progress. One plan developed better data to identify statewide areas with very low prenatal birth weights but did not succeed in persuading providers to participate and lacked funding to support incentive payments. Across all participants, the most troubling obstacles to improvement were (1) obtaining and analyzing data to generate meaningful, interpretable results, (2) securing dedicated resources for managing and operating programs, (3) maintaining adequate management support, and (4) staff turnover.

In almost no cases did plans collect and maintain data on the outcomes of their interventions other than through the types of process measures noted above. In fact, lead staff for the first BCAP voiced concern from the start about making demonstrable improvement on birth outcomes given the lack of a strong evidence base. Given the frustration of some participants, the plans agreed that they would like to see more basic instruction in quality as well as assistance in measurement and the technical aspects of data management. They also wanted better communication of results or outcomes from the other participating plans.

All of the plans participating in BCAP 1, however, agreed that the experience was valuable; it provided an opportunity for sharing ideas and attacking common problems. Though 7 of the 10 plans interviewed for the evaluation said they would have worked on birth outcomes initiatives anyway, they also said that the initiatives would not have progressed as far along if they had been implemented in the same way without CHCS. They said BCAP made their efforts more rigorous and organized and that they knew of no other place to get such Medicaid-focused information. Many also said their participation had affected other plan initiatives. Examples include use of risk assessment tools and database software for other conditions, adapting outreach to those with other conditions, or use of BCAP experience to demonstrate the commitment needed to obtain grants to pursue other quality improvement initiatives. At least two reported in the interviews that they had become involved in another plan collaborative—sponsored by MMCP or by others—after the positive workgroup experience.

b. BCAP 2: Improving Preventive Care Services for Children

The second BCAP focused on improving preventive services for children—immunizations and well-child visits (Mittler and Humensky 2004). We experienced greater difficulty in contacting plans in BCAP 2 than in the other BCAPs. Of the 11 plans that participated in BCAP 2, one went out of business and another dropped out after the first workgroup meeting. We were able to talk with eight of the nine remaining plans (one refused), though with all but one plan, only a single staff member participating in BCAP 2 remained with the plan. Of the eight plans, six implemented all of their planned activities, one implemented all but one activity, and one completed no activities. The seven plans completing activities generally sustained them, with

four reporting that BCAP 2 had become part of normal plan activity.[30] When such integration occurred, it was harder to identify whether plans had continued to make changes in response to experience or cutbacks as visibility decreased. Some evidence supports a conclusion that at least some plans strengthened and some limited their approaches after the conclusion of BCAP 2. Plans said that they faced few serious problems in sustaining their initiatives because states assign high priority to immunizations and well-child visits.

Four plans chose to focus on childhood immunizations, two on well-child visits for young children, two on well-child visits for adolescents, and the remaining one on reminders for both immunizations and well-child care for young children. For immunization programs, plans typically targeted high-volume providers, developing lists of members who were in need of immunizations, sending the lists to providers, and conducting follow-up to educate providers. To encourage compliance with immunization schedules, plans also made direct contact with members whose children were in need of immunizations and distributed literature on the importance of immunizations. Well-child initiatives shared many common features but were more likely to add either member or provider incentives to encourage receipt of preventive care.

While not always an explicitly defined activity, many plans developed databases to track progress and inform outreach. Plans often faced data problems and resource constraints as they pursued their initiatives. For example, to obtain accurate information on immunization status, plans found they had to refer to medical records or locate members whose contact information was inaccurate. Well-child activity was limited because of problems associated with issuing temporary identification numbers to babies before delivery or merging eligibility information

[30] One of the seven plans completing its activities implemented all but one. The eighth plan completed none of the activities after the original medical director left the plan. The plan that refused our interview reported progress to CHCS in March 2002, but we could not update its experience without an interview.

from schools with plan information. Successful implementation was much more likely for a plan with a leader who made the project a priority, and with adequate resources, including staff.

Given that the activities under BCAP 2 tend to have outcomes that may be captured, at least in part, through the types of HEDIS data that plans are supposed to report to states, many participants could point to at least some relevant outcomes data for their initiatives. Four of the seven plans reported improvements that included increases in well-child visits, immunization rates, or the number of newborns with a primary care physician (PCP) delivery. Examples include an increase after BCAP 2 in adolescent EPSDT rates from 30 to 41 percent and a 30 percent increase in HEDIS up-to-date immunization rates between 1998 and 2001. Data on measures outside the purview of HEDIS were rare. Intermediate process rates (e.g., missed opportunity rates) were generally thin and then lacking entirely once BCAP 2 concluded.

Plans said that BCAP 2 had the advantage of motivating them to focus on a substantive area, develop an action plan, and move forward with it. Networking and learning from each other were among the most important benefits of plans' participation in the workgroup. All but one of the seven plans that implemented activities under BCAP 2 said that learning the framework contributed to a stronger overall approach to quality improvement. At least four said that they were using the BCAP framework for other activities, though only two mentioned specific topics. As with birth outcomes, plans said that they probably would have pursued activities in the various areas without MMCP, though not as rapidly or well. The only suggestion for improvement, offered by more than one plan, was CHCS' or RWJF's provision of seed money for the initiatives. Several plans noted that they were facing tight budgets and were therefore competing for resources within their plan; "even $20,000" would have been helpful in "getting projects off the ground" rather than trying to squeeze an activity into already overloaded agendas and onto overworked staff.

c. BCAP 3: Achieving Better Care for Asthma

Of the 11 plans in BCAP 3, we spoke with all of them about six months after the conclusion of Phase 2 and found that all 11 plans had implemented their planned activities and that eight had continued them after the BCAP ended (Krissik and Mittler 2004).[31] Seven of the eight plans said that they definitely planned to continue their asthma programs in the future, citing corporate commitment, availability of resources, and a recognition that asthma care is important in the Medicaid program. Some of the plans had either operated disease management programs (3) or were working under a concurrent grant from RWJF's Improving Asthma Care for Children (2).[32] The intentional overlap was a strategy to help plans leverage resources to make needed change. It is important to note that the joint support raised the prominence of asthma work in the participating plans, added to the resources available to address clinical needs, and provided resources important for building clinical quality information systems.

Plans involved in BCAP 3 pursued similar types of activities. Asthma registries were common (six plans, all still in place) as well as extremely important in helping plans identify asthmatics and stratify them by risk; plans that did not develop registries experienced difficulty. Outreach was another important activity, although eight said that telephone outreach was problematic because of inaccurate telephone numbers. Instead, five plans turned to home visits or relied on the provider to provide outreach. Reaching target goals for outreach was challenging. Some plans set their goal particularly high (e.g., 100 percent contact of asthma members) and did not reach it. Other common initiatives were improved appropriateness of

[31] Of the other three, one lost grant funding, forcing it to discontinue all but one BCAP activity; a second put its asthma activities on hold until it filled a recently vacated asthma director position; and the third had recently been purchased by another plan, leading it to stop temporarily a number of its activities so that it could adjust to the change in ownership.

[32] Plan 1 received a grant from RWJF's Improving Asthma Care for Children Initiative after beginning its participation in BCAP 3.

pharmacotherapy for asthmatics (three plans), education of providers (three plans) and employment of the Asthma Therapy Assessment Questionnaire to assess members' conditions (two plans).

Examples of the changes introduced by a diversity of plans include the following:

- Plan 1 (also a participant in BCAP 1) standardized its process of identifying asthmatic members, stratified them by severity level, conducted outreach to identified members by mail and telephone to enroll them in the plan's disease management program, and worked to ensure that they received a follow-up visit with an appropriate primary care provider or specialist. As a result of these activities, the plan experienced a four-fold increase in enrollment in the disease management program and believes that it reached 50 percent of its members with asthma. The plan has recently developed an automated registry to help with identification and tracking. The plan experienced significant challenges related to capturing relevant and valid data and to gaining physician involvement in the intervention.

- Plan 2 developed an electronic asthma registry that it has since adopted for use in other programs. With the registry, the plan was able to stratify all of its children with asthma (age 2 to 18). Plan 2 was in the process of using the registry for outreach and tracking follow-up needs. It was using a system to identify members with "out of control" asthma and provide them with an asthma action plan, including home visits and assessments. By June 2002, the plan had developed an action plan for 63 percent of its asthma members as compared with a goal of 80 percent within three months of identification. Staff turnover and lack of management support have stalled further progress.

- Plan 3 developed a registry aimed at improving the identification of asthmatics by use of several data sources, particularly longitudinal claims. Its identification rate rose from 7 percent at the outset to 11 percent in June 2003. The plan stratified members by severity and, after finding it easier to reach severe rather than moderate asthmatics, worked with providers to ensure success in reaching the former group; in fact, it offered bonus payments to providers for change in practices. Over 12 months, contracted physicians increased their prescription of preventive asthma medication by 6 percent, and the percentage of asthmatic members using the emergency room declined. Primary challenges included poor contact information, staff turnover, and difficulty in moving beyond annual measurement (as is standard) to more frequent measurement (which is desirable for BCAP-like programs).

- Plan 4 had a disease management program in place before BCAP 3 and used the workgroup to enhance its activities. The plan increased identification of members with asthma from a 3 percent baseline to 5 percent, gave providers reports on asthmatic members, informed providers about the plan's disease management program, mailed educational materials to asthmatic members, and notified providers about asthmatic members' inappropriate uses of medications. With limited resources, Plan 4 found it difficult to identify the highest-risk members who would most benefit

from the intervention. The plan also struggled with limited support staff but credits support from management as a factor in its success.

Though all the plans collected data, only seven had analyzed their data by the end of the workgroup, although many continued to maintain measurements. Some of the data are process-oriented (e.g., asthma members identified, contacts made, number of members with action plans). Outcome measures included emergency department utilization, number of clinic visits, number of missed school days, and use of controller medications. One plan calculated a return on investment. At the end of the workgroup, all plans had increased their identification and stratification rates for asthmatic members, and nine plans reported a decline in emergency room use or hospitalization reports.

Data reporting appears better developed for BCAP 3 than for the earlier two workgroups. One medical director noted, for example, that the emphasis on data-driven outcomes represented a paradigm shift for this plan, which three years ago did not collect outcome data. He attributed the shift to a desire to get the most "bang for the buck" and, in some cases, justify the continuation of disease management programs. A few examples (in addition to those noted above) of outcome improvements include a decline in price per asthmatic member per year from $1,017 to $339 in 2002 and a decline in unscheduled visit rates for those in the program from 18 to 10 percent with a concomitant increase in scheduled visits from 33 to 69 percent.

Ten of the 11 plans called BCAP 3 a positive and worthwhile experience.[33] As with BCAPs 1 and 2, participants in BCAP 3 credited the workgroup with pushing them forward with activities and helping, in the words of one plan staffer, to "keep us focused. They push, push, push, but when you have so much on your plate, it's great to have someone there to remind you

[33] The 11th said it could not distinguish BCAP from its grant experience and perceived that seminars attended by plans unduly pressure plans to join BCAP.

of what needs to get done." Six plans said that the monthly or quarterly calls and the BCAP structure and schedule were the most important benefits of participation.

As with other workgroups, participants in BCAP 3 viewed the opportunity to network and share experiences with other plans as a major benefit. Their participation in the workgroup helped them learn "what works" and not "reinvent the wheel." At least half the plans interviewed for the evaluation also said that the emphasis on both process and outcome measures carried over into their general approach to quality improvement. Seven specifically said that the focus on such measures changed the way they think about quality improvement, with six reporting that they applied the BCAP framework to other conditions such as diabetes, congestive heart failure, end-stage renal disease, and care for children with special health care needs. In addition, three of the plans said that they intend to use electronic registries to track other conditions. As before, plans typically said that they probably would have become involved in asthma management without CHCS but that BCAP helped them do so more rapidly and in a way more appropriate to their needs. Plans also noted that the Medicaid focus behind CHCS was unique and valuable in view of the distinctive characteristics of the Medicaid population. Several said it would be useful for CHCS to maintain a database that would help them continue tracking their colleagues' outcomes from their asthma activities.

d. BCAP 5: Improving Care for Adults with Chronic Illness and Disability

Twelve plans participated in BCAP 5, whose final phase concluded in April 2004. We interviewed each plan about three to four months thereafter to learn about its accomplishments, the sustainability of those accomplishments, and its views on BCAP. All but one plan (whose state had moved to a PCCM model) was still involved in Medicaid managed care when we spoke with them. At the time of our calls, BCAP projects were still operating in 10 of the remaining 11 plans, although only seven plans were relatively certain that they could continue their project

given the fiscal constraints they and/or their states faced. But of the seven plans, five were planning to expand their activities.

Interventions in BCAP 5 varied to a greater extent than in the previously discussed BCAPs; the workgroup targeted a highly diverse population (adults with physical and chronic illnesses), leading most plans to develop targeted interventions for subgroups of the population. Of the 11 plans still involved with Medicaid, four targeted members dually diagnosed with both physical and mental conditions,[34] five targeted specific combinations of physical conditions and disabilities,[35] and three decided to deliver relatively untargeted interventions for all disabled adults.[36] A common link across the interventions was a focus on improving care coordination and use of a case manager. Many also emphasized interventions to help members manage their conditions.

In general, plans with a clear focus seemed more likely to achieve gains. Such plans had identified a well-defined population and an intervention well suited to the population's needs and consistent with the resources available to the plan. Four examples follow:

- ***Plan M.*** The intervention targeted 50 SSI members suffering from congestive heart failure or diabetes and other complications and residing in rural areas. It was structured around telephonic case management to help with self-management and provide advance warning about uncontrolled conditions that require member contact. Initial reports of physician resistance were countered by employing a local case

[34] The four included a provider communications protocol and case managers for patients with diabetes with depression; an initiative operated by a small, specialized plan that was originally designed to help minimize harm for members with substance abuse but that evolved into provider education when sufficient referrals were not forthcoming; an effort directed at better coordination of medical response following discharge for mental illness; and case management and a recommended "mall walkers" program for severely and persistently mentally ill in a PCCM.

[35] The five included two focused on diabetics with comorbidity; a third focused on immobile individuals at high risk for pneumonia, urinary tract infection (UTI), or mechanical bowel obstruction; a fourth focused on those at high risk for preventable comorbidities but not necessarily specific to any single condition; and a fifth focused on members using chronic pain medication.

[36] One used a case management/primary care case manager model to coordinate care, another coordinated care for those discharged from a hospital, and a third was involved in outreach and offered incentives to SSI members who did not make a visit in the past year.

manager familiar with the culture. The program was undergoing expansion into other areas of the state, including urban areas, and had enrolled over 200 members.

- ***Plan N.*** This small, specialized plan with about 70 members at the start of the BCAP (now 400) used BCAP 5 to build on its existing care coordination model, which was partly funded by a MMCP demonstration grant. The specialized plan conducted a needs assessment showing that 70 percent of its members were at risk for three preventable conditions associated with immobility—pneumonia, urinary tract infection, and mechanical bowel obstruction. The intervention aimed at educating at-risk members about symptoms and the importance of rapid response, constructing consumer-empowering protocols to be followed by members, and developing educational materials and educating primary care physicians. The plan has sustained the intervention; as plan membership grows, new members are being added.

- ***Plan O.*** The plan used its participation in BCAP 5 to implement the chronic pain management program it already started to develop. The intervention included a registry to identify members with chronic pain issues, a clinic-based self-management program in several clinics across three network health systems, and a chronic pain management program for providers. Plan O trained clinic staff and created a steering committee so the clinics could assume full responsibility for sustaining and perpetuating the clinic. As a result, the clinics continued operations when Plan O's funds were cut 20 to 30 percent in mid-2003, though the program could no longer support pain management classes or data analysis. The registry remains in place, however. Plan O said that its finances have since stabilized. It expects to renew the program since "with minimal investment, we can have a significant impact."

- ***Plan P.*** This very small, specialized Medicaid plan originally intended to help members with substance abuse minimize the harm caused by the addiction ("harm reduction programs"). When the plan identified only 30 such members among a membership of more than 200, it determined that providers were unable to identify those with addiction problems. The plan therefore worked on provider education followed by coaching. It came to realize that an important type of treatment calls for assisting members with such problems in learning how to deal with their own shame, denial, and anger around substance abuse. The program was undergoing expansion to other members, with the education model to be applied to other conditions.

The above plans were much more likely than other BCAP 5 participants to have collected data on the improvements generated by their interventions. Plan M demonstrated a decline in hospitalization rates, length of stay, and total monthly costs per member that have led to a 47 percent reduction in costs. Plan M also said that it has received positive feedback from patients who have reported that the intervention has helped them make better use of the system, cooperate more fully with providers, and schedule visits more easily. Plan O's assessment of the first pain

management groups showed small and consistent (though not statistically significant) decreases in hospitalization and emergency room, primary care, and prescription drug utilization and costs as compared with similar nonparticipating users. Anecdotal feedback from participants and group leaders is said to be powerful. For example, one participant said, "You kept me off the bridge." Plan N said that its small size made an impact assessment difficult, but it believed that it is seeing improvements for two of the three conditions of interest: bowel obstruction and pneumonia. Plan N also said that it had identified and was addressing certain process problems around laboratory turnaround and communication of results. Resolution of those problems, according to Plan N, might make a difference for the third condition (urinary tract infection). In addition, Plan N received a Business Case for Quality grant to examine the business case for its urinary tract infection intervention. Plan P has not collected outcome data but said that staff are positive on the value of the education they received as part of this BCAP.

Though BCAP 5 also yielded other interventions that show promise, the plans seemed to struggle more than those in the other BCAPs. Of course, BCAP 5 targeted a particularly challenging group whose diversity and range of conditions are important concerns in Medicaid. The plans themselves appear to have recognized the nature of the targeted population when they pressured CHCS to add a new, first step to the typology—needs assessment. The specialized needs of the population and its complicated care patterns demand the creation of a solid logic model for each intervention. In fact, in some cases, outcome indicators appeared insufficiently targeted to the interventions (e.g., per capita utilization generally versus target population utilization).[37]

[37] In part, this may reflect the difficulties of using benchmarks for subgroups of Medicaid beneficiaries with specific needs. BCAP 5, in fact, aimed to develop some of these benchmarks by collecting data on the populations.

Given the critical role of providers in dealing with the high-risk individuals targeted in BCAP 5, participants learned that provider "buy in" is essential yet challenging. Further, data that are sufficiently specific to the targeted intervention are important but evidently not easy for plans to identify or generate.

As with the other BCAPs, plans involved in BCAP 5 appreciated the opportunity to participate. All but one of the plans said that the activities were extremely valuable, especially the opportunity to build connections to other plans with other focus areas, even within Medicaid. As one plan said, "The Center created the thread that connects us to other health plans. Otherwise we would be in isolation."

More so than in other BCAPs, participants in BCAP 5 struggled with the typology, though most ultimately said that they came to appreciate its structure and rigor. Given their respective target populations, participants wondered if some of the categories—such as identification and stratification, or stratification and outreach—overlapped. Participants perceived that their interventions would not have succeeded without their involvement in the workgroup, but some still found the format "too mechanical" and characterized the monthly reporting as "tedious or redundant." But another observed, "We went there kicking and screaming about the typology. It was a way of forcing you to think differently. . .but I have to say that we probably use it every day now. We're reformed believers." To reduce frustration, one plan recommended "typology 101" upfront as well as additional work so that plans would "not get hung up on the vocabulary" and instead would view the typology as the traditional Plan, Do, Study, Review (PDSR) cycle and standard total quality improvement model.

C. DEVELOPMENT OF COMMUNICATION STRUCTURES

CHCS has developed a number of communication structures which plans regard as valuable in a variety of ways. The BCAP Network Listserv and the CHCS Network Exchange Calls are two important examples of recent development.

The BCAP Network Listserv was created in early 2002 as means of electronically linking plans to one another. This listserv, which currently includes about 340 members, allows plans to communicate with one another on a wide variety of issues related to quality improvement. Plans generally use the listserv as a forum in which to pose questions to the group and gather feedback on other plans' experiences with or approaches to a particular issue. Some plans also use the listserv to inquire about sources for technical information. In the summer and fall of 2004, questions posted on the listserv included the following:

- For adult members with **asthma**, what specific barriers with medication adherence (long-term controllers specifically) have you experienced? What techniques have been effective in reducing utilization and costs across the board?
- What percent of your total deliveries are detained babies and/or **NICU babies**? What are your benchmarks for admits/1000 or days/1000 in NICU?
- Have you sent outreach materials on **flu vaccine** to your members and if so, did you send to only those at "high-risk" or all of your health plan members? Have you tried to evaluate the "effectiveness" of these activities? (posted prior to vaccine shortage)
- Do you have any suggestions for how to improve provider compliance with **chlamydia screening** or ideas for what else might be contributing to our low screening rate? (plan provided some background about their own experience)
- How do other plans go about identifying members with **diabetes**? We would be interested in hearing about any methods being used to minimize the rate of false positives.

Typically, multiple plans respond to each request for information, often with information on their own experiences in addressing the issue or at least with suggestions of other information sources. In the last six months, more than 90 messages were posted on the listserv.

In our communication with plans participating in BCAPs 1, 2, 3, and 5, many explicitly noted the usefulness of the listserv and felt that CHCS had developed a sense of community through this vehicle. Moreover, plans also enjoy seeing what other plans are working on through the topics explored on the listserv and the fact that others face similar challenges has helped to create a sense of camaraderie. (For more information, see Mittler, Krissik, Gold and Humensky 2004.)

One of CHCS' most important roles involves its ability to convene key stakeholders to discuss emerging issues. To further this objective, CHCS established the BCAP Network Exchange Calls in 2003 as a forum to discuss issues in quality improvement and share best practices among participants. At times, the Center also has used the activity to advance its strategic objectives by sponsoring calls on topics that it views to be important, such as return on investment. Currently, CHCS runs a parallel structure: calls with health plan staff and calls with state Medicaid staff but most resources for this activity have been devoted to sessions for health plans. The calls developed from an ad hoc framework that presented findings from CHCS studies into their current form. More recently, the teleconference is offered bimonthly for health plans and states, featuring CHCS experts and guest presenters. The calls last 90 minutes and allow time for questions and feedback from participants.

Since the Network Exchange Calls were first established in 2003, they have brought together health plans and purchasers nationwide to learn about a range of topics. CHCS has organized calls targeted to health plans that include the following topics:

- MCO Performance Incentives
- Return on Investment: Making Quality Pay
- Evidence-Based Practices in Children's Behavioral Health
- Techniques for Screening Children with Special Health Care Needs

- Linking Emergency Department Initiatives with Social Case Management
- Predictive Modeling
- Working with Providers to Improve Asthma Management: Office-Based Education and Provider Profiling
- The Business Case for Improving Birth Outcomes
- Designing Culturally Competent Oral Health Services

State purchasers have participated in teleconferences that include:

- Clinical Pharmacy Management Initiative: Integrating Quality into Medicaid Cost Containment
- Performance-based auto-assignment

After each Network Exchange Call, a staff member from CHCS types up a meeting summary and posts it on the CHCS Web site.

D. PLAN PARTICIPATION BY THEIR STATES' LEVEL OF SOPHISTICATION

We also examined whether plans located in more sophisticated states were more likely to be aware of CHCS or participate in its activities.[38] (Our description of state sophistication measures in Medicaid managed care is provided in Chapter IV.) The number of plans at each sophistication level is small, but plans in states with higher levels of sophistication in Medicaid managed care appear more likely to be aware of CHCS, relative to plans in states with lower levels of sophistication.[39] Plans in states with higher levels of sophistication also generally participated in more CHCS activities, though not to a statistically significant degree. Finally, we also found that, regardless of sophistication level, awareness of CHCS by states and awareness of

[38] Participation for this analysis was based on plans self-reports of participation, not administrative records.

[39] Given the small number of plans in each sophistication category, there are only a few marginally statistically significant differences, such as the percentage awareness among plans in states with high sophistication versus plans in states with no sophistication ($p<0.10$).

CHCS by plans within those states was slightly positively correlated, but not to a statistically significant degree.

E. SUMMARY OF FINDINGS

This chapter reviewed findings that speak to the question of whether MMCP has helped plans improve care delivery and make enduring change. On a number of measures, the findings are relatively positive, but significant challenges remain. MMCP reached over a quarter of all Medicaid managed care plans nationwide through a BCAP workgroup or workshop, and plans credit the BCAPs with improving the way they deliver care. When we looked in depth at plans receiving the most intensive support (as a result of participation in BCAP workgroups), we found that the large share of plans in each workgroup succeeded in implementing change—and most of these plans appeared to be positioned to sustain activities into the future. Plans also reported that BCAP motivated them to change the way they think about care delivery and spurred other plan changes. Though measurement is a core part of the rapid-cycle model, substantially fewer plans were able to track the outcomes of their interventions, and experience with process measures varied across BCAPs. BCAP 3 is probably the most successful workgroup to date, though BCAP 5 generated a few models that may have substantial potential to transform care delivery more broadly for the chronically ill. When logic models for intervention and measurement are absent, plans seem most likely to struggle. In many areas, plans and BCAP staff still appear to be struggling with how best to generate measurements critical to a plan's success or, at least, to a plan's ability to demonstrate success.

MMCP's success in working with plans was limited almost exclusively to the set of heavily Medicaid-dominated plans that have gravitated to BCAP. Such an outcome was probably unavoidable and may not be undesirable when so few other resources focus on the needs and constraints of Medicaid-dominant plans.

Surveys of participating Medicaid health plans in both 1997–1998 and 2001 show that Medicaid-dominant rather than commercial plans are more likely to adopt a focus specific to the needs of the Medicaid population, though both plan types evidence room for improvement (Landon et al 1999; Felt-Lisk and Gold 2003). Both types of plans carry out quality improvement initiatives relevant to Medicaid beneficiaries, but commercial plans were somewhat less likely to focus on conditions of particular relevance to the Medicaid population (e.g., asthma, violence, HIV), and their outcome data were less likely to be targeted specifically at Medicaid enrollees (Felt-Lisk and Gold 2003). At least in 1997–1998, commercial plans were also less likely to operate specialized programs targeted to patient needs in the areas of inadequate transportation, lack of a telephone, and illiteracy (Landon et al 1999). Without a base in commercial plans, MMCP is unlikely to influence the modification of their current patterns, especially given the limited economic incentive for commercial plans to succeed in the Medicaid market. Further, little evidence suggests that quality of care differs between the two types of plans, though it may be reflected in different ways.

Finally, MMCP's experience in working with plans shows that success in improving care requires substantial investment—both from MMCP with respect to technical assistance resources and from plans with respect to investments of staff time and developmental resources. BCAPs that faltered often experienced turnover in leadership and/or staff and adverse financial circumstances. Plans surveyed for the evaluation noted that the primary barriers to improved care were state economic difficulties (85 percent), low capitation rates (77 percent), and restrictions on state funds to finance plans' costs for action needed to improve care (65 percent). Not surprisingly, the plans that made substantial progress in their work with MMCP benefited from a substantial investment both external and internal to the plan.

VI. HAVE CONSUMER GRANTS BEEN EFFECTIVE IN ACCOMPLISHING THE CONSUMER ACTION AGENDA?

A. IMPORTANCE AND METHODS OF ASSESSMENT

Conceptually, consumers—those who potentially need and may benefit from timely receipt of high-quality health services—are vitally important to the effective operation of Medicaid managed care. Yet, while consumers are CHCS' third major audience, MMCP funding in support of consumers' improved navigation of the health care system and participation in system governance has been limited. For the most part, CHCS' efforts to promote the Consumer Action agenda have relied on relatively small grants (McHugh 2004). Therefore, our evaluation of the Consumer Action agenda is based solely on what the surveyed consumer groups said about the agenda and what we learned from grantees about the changes that the grants permitted them to make.

B. OVERVIEW OF CONSUMER ACTION GRANTS AND OUTCOMES

The purpose of Consumer Action grants, as stipulated in the first call for proposals in 2001, was to strengthen the capacity of consumers and family members to navigate publicly financed managed care systems and to establish a formal role for consumers and their families in designing, implementing, and monitoring publicly financed managed care programs. CHCS solicited proposals from consumer organizations, family organizations, and advocacy groups that could demonstrate a commitment to help consumers understand and influence the design of health and health–related services. Grantees had to be located in areas with a substantial volume of publicly financed health and behavioral health care. CHCS awarded the first round of grants, worth up to $25,000 each, between March and September 2001. Nineteen organizations received grants, 10 of which were local initiatives under RWJF's Covering Kids and Families Initiative that went to fund statewide coalitions dedicated to increasing the number of children and families

benefiting from existing health care coverage programs. Given that RWJF is separately evaluating the Covering Kids grants, we do not discuss them here. In 2002, CHCS funded another round of grants, increasing the maximum dollar amount to $50,000 each. These grants targeted projects that focused on disability and chronic illness. In addition to the previously mentioned goals, the latter grants were authorized "to promote the ability of consumers to gain access to needed health care services."

Grantees were geographically concentrated in certain areas of the community and were of various size. Of the 19 grantees studies from both rounds, most were located in the East (10) or West (7); only two were in the Midwest and none in the South. Six had an annual budget under $500,000, whereas seven had an annual budget between $1 million and $10 million, and two had a budget of $10 million or more. Most of the grantees were private not-for-profit organizations funded through a combination of federal, state, and private grants and most classified themselves as consumer organizations, advocacy groups, or family support organizations. About half focused on general community well-being and health improvement while the other half, typically in round 2, focused more specifically on supporting parents and families with disabilities and/or chronic illnesses. Most grantee organizations were governed by a board of directors, with consumers comprising at least 50 percent.

1. Grantee Focus and Accomplishments

To facilitate our analysis of grantees' focus and activities, we designated the activities conducted under the grant as either "primary" or "secondary." Primary activities were designed to address the goals of the grant program and required a substantial amount of time and effort. Secondary activities supported primary activities. For example, one grantee conducted a series of education seminars for consumers (primary activity) but also spent time recruiting consumer participants and developing topics for the seminar curriculum (secondary activities). Our

analysis focuses on primary activities, which represent the core activities covered under the grant.

Sixteen grantees conducted at least one primary activity to help consumers and family members navigate the health care system; of the 16 grantees, 10 worked to establish a formal role for consumers and family members in the system, and six helped consumers gain access to needed services (see Table VI.1). Many grantees worked on several activities, of which five were particularly common: education seminars designed to improve consumers' navigation and/or advocacy skills; development of written materials to help consumers navigate the system or improve policymakers' understanding of system barriers; arranging for consumers to collaborate with policymakers, providers, and health plans; consumer peer mentoring; and advertising or expanding a consumer assistance telephone line. The amount of the grant limited the size and scope of the activities. For example, respondents collectively reported that they trained more than 1,188 consumers at their education seminars.

Grantees said that they implemented the large share of their proposed activities. They attributed their implementation success to their experience in working with consumers and their strong connections to the local community, both of which were organizational attributes targeted by CHCS in its solicitation. Most grantees carried out their activities at the proposed level of intensity, but 13 of the 18 grantees interviewed for the evaluation experienced some difficulty in completing their activities within the one-year time frame; many required two- to three-month extensions. The majority of grantees believed that they were successful both in helping enrollees navigate and access the Medicaid managed care system and in developing a role for consumers in the design of that system (see Table VI.2). Few grantees said that the technical assistance provided by CHCS strengthened their activities; assistance generally took the form of conference calls.

TABLE VI.1

ACTIVITIES PROPOSED AND CONDUCTED WITH CONSUMER ACTION GRANT FUNDING

	Number of Grantees That Proposed the Activity	Number of Grantees That Conducted the Activity	Number of Grantees That Conducted the Activity at the Intensity Proposed
Activities to Help Consumers and Family Members Navigate the Medicaid Managed Care System	15	16	NA
1. Hold education seminars to teach consumers how better to navigate the system	12	12	7
2. Create and disseminate educational materials	11	12	11
Materials on how to access services	8	9	8
Materials on the education seminars held for consumers	3	3	3
Creation of a resource library	1	1	1
Public service announcements	0	1	0
3. Advertise or expand consumer help line	2	2	2
Activities to Establish a Formal Role for Consumers and Family Members to Design, Implement, and Monitor Medicaid Managed Care	12	10	NA
1. Hold education seminars to teach consumers how to participate in system design and monitoring	9	9	7
2. Arrange for consumers to participate on policy, provider, or health plan boards or committees	6	5	4
3. Arrange informal meetings between consumers and policymakers, providers, or health plan staff	5	4	2
4. Develop materials that outline system barriers	3	3	3
Activities to Help Consumers Gain Access to Needed Services[a]	6	6	NA
1. Develop peer support services	6	4[b]	3
2. Implement transportation services	2	0	0

Source: Interviews with 18 grantees and a review of grantees' applications and final reports.

NA = Not applicable

[a]This was a goal only for round 2 of Consumer Action grants. Ten organizations received grants in round 2.
[b] Two additional grantees still plan to implement the activity; the project time frame has been delayed.

TABLE VI.2

REPORTED SUCCESS BY GRANTEES

	Number That Conducted Primary Activity in the Area	Number That Reported Success and Conducted a Primary Activity in the Area	Number That Reported Success and Did Not Conduct a Primary Activity in the Area
Goal 1: Help consumers navigate Medicaid managed care	16	14	0
Goal 2: Help consumers play a greater role in designing, implementing, or monitoring Medicaid managed care	10	8	3
Goal 3: Help consumers gain access to needed health services	6	5	7

Most grantees documented the number of consumers they reached directly (e.g., number trained) but believed that many more consumers benefited from grantee activities through word of mouth and reproduction of written materials or the grantees' effectiveness in changing state practices. A number related specific accomplishments that include:

- A hospital that added a directory to guide patients
- A community that established task forces on hepatitis C and diabetes
- A state that set up a task force to look into mental health services and to develop recommendations for systems improvement
- A state department of mental health that began funding a peer mentoring program
- A state Medicaid agency that hired additional enrollment workers
- A state that provided better training for Medicaid case workers
- A health plan that distributed a new set of educational materials to enrollees
- Plans and providers in one community that translated educational material into different languages

Nonetheless, aside from grantees' reports, evidence of change in consumers' knowledge and/or behavior was limited.

2. Sustainability of Activities

Grantees experienced difficulty in obtaining funds to sustain the Consumer Action grant–supported activities beyond the grant period. Ten of the 18 grantees interviewed for the evaluation managed to sustain at least one activity following the grant period; in many cases, however, the intensity of activities declined at the end of the period. Only one grantee reported the receipt of private funding to maintain project activities; six reported the receipt of public funding for educational activities but said that the funds were secure for only the short term. A few grantees managed to sustain some activities by partnering with other organizations or relying on volunteers. And while many grantees believed that their written material could find broad application and that their activities could be replicated by other groups, they generally were unaware of any such outcome. CHCS did not require grantees to engage in communication and did not disseminate the work itself.

3. Views of the Consumer Action Grants

Grantees said that the grants were tremendously important to their organization; only one said that her organization would have been able to carry out its project activities in the absence of the grant. Aside from their direct contribution to outcomes, the grants proved particularly valuable because of their uniqueness—grantees could not identify another funding source to support the goals of the Consumer Action agenda. In addition, the grants meant that CHCS recognized consumer, family, and community groups as important stakeholders in the Medicaid managed care system, and that recognition helped some groups in their efforts to work with states and health plans. The survey results described in Chapter III confirm these findings.

CHCS is no longer funding Consumer Action grants as part of MMCP. To accommodate changes in its own funding, CHCS is in the process of recasting its strategies for assisting consumers by shifting from grant making to technical assistance—if it provides assistance at all (White and Gold 2004). Those few grantees aware of CHCS' change in direction at the time of the interview registered disappointment in CHCS' decision. As they saw it, the elimination of the grants for consumer organizations left groups with few, if any, alternatives for initiating activities that address consumer decision making related to managed care, whereas much more significant grant opportunities were available to states and health plans.

C. SUMMARY OF FINDINGS

Even though CHCS allocated only limited resources to the Consumer Action grants, the grants earned high marks from consumer groups that worked hard to execute them. By and large, the grantees were effective in conducting their proposed activities and in accomplishing a lot for relatively little money. However, the Consumer Action grants apparently left little mark on their environment. The grants were too small, too localized, and too short-lived to have a long-term impact.

In our original short-term assessment of MMCP, we noted that consumer groups raised concerns about "tokenism." According to our evaluation findings, we have to concur that the facts support such concerns. While CHCS identified consumers as one of its three core audiences for MMCP, its funding levels for consumer activities did not support the rhetoric. Throughout much of health care history, the empowerment of consumers has been a lofty but empty goal. Ironically, except recently when consumers' cost-sharing obligations increased in the belief that the increases would motivate consumers' assertiveness, few mainstream sources have targeted funds to empower consumers. CHCS has started to rethink its approach to consumer involvement and, specifically, whether it is the organization best suited for promoting

consumer action in Medicaid managed care. The unmet needs for improving care are great and MMCP has some potential to address them, but others may be more appropriate to take the lead here. However we must argue that CHCS owes it to consumer groups to be more forthright about what it can and cannot offer and where consumers fall on the list of program priorities.

VII. THE TRADE-OFF BETWEEN GRANTS VERSUS TECHNICAL ASSISTANCE

A. IMPORTANCE AND METHODS OF ASSESSMENT

MMCP began as a grant program and transitioned to a program of grants combined with direct technical assistance. Now, with the desire to stretch resources for an additional two years and the consequent limits on grant funds, CHCS is awarding fewer grants and limiting almost all of those it makes to token amounts in order to engage stakeholders, especially plans, in collaborative efforts with MMCP to improve care and demonstrate improvements. Because grants initially constituted MMCP's core focus, and grants have accounted for a meaningful share of MMCP's spending since its inception, we review what MMCP has accomplished most recently through its grant giving and briefly discuss the evaluation findings that are relevant to consideration of future trade-offs between grants and technical assistance.

Between 2000 and 2003, CHCS accepted applications for both open and targeted grant solicitations (Taylor and Gold 2004).[40] As discussed, grants included large model demonstration awards most commonly in the range of $400,000 to $500,000, though the maximum size varied over time,[41] as well as smaller grants, typically $100,000 or less that support a variety of best practices and policy studies conducted by health plans, providers, state agencies, and research organizations. CHCS staff review the grant applications and send those passing the initial screen to MMCP's National Advisory Committee (formerly called the National Review Committee) for

[40] Since mid-2003, the center's grant making has largely responded to targeted solicitations (e.g., The Business Case for Quality in Medicaid). CHCS said that it planned to fund no more than four to five unsolicited ad hoc grants per year (see White and Gold 2004).

[41] Historically, the grants could be awarded for up to $500,000. In 2002, the amount increased to $750,000. CHCS can still make grants up to $750,000 but does not expect to do so. In 2003, CHCS instituted a new policy, whereby the Board needs to give special approval for MMCP grants over $250,000.

review. The CHCS board conducts a final review and approves the grant awards. (For more information on grant making, see White and Gold 2004).

Table VII.1 provides information on the number of grant awards of each type (not including the Consumer Action seed grants already discussed in Chapter VI) made by MMCP between January 2000 and mid-2003. Although MMCP awarded only 18 model demonstration grants during the period (12 full-scale grants and six planning grants), they tended to be large and therefore accounted for $5.4 million of MMCP's awards. In contrast, MMCP spent $3.9 million on 50 grants for best practices and policy studies, of which $2.5 million went to research organizations. It spent an additional $0.6 million on community integration grants awarded in 2000 on a one-time basis. Most grants of all types have been awarded to organizations in the East (see Table VII.2), though, without information on applications, we cannot determine how awards compare with applications.

To assess grantees' experiences with the model demonstration grants, we conducted semistructured interviews and reviewed available documents on all of the model demonstration grants completed or nearly completed and on a sample of other grants, stratified by sponsor (see Taylor and Gold 2004 for details). Given that the model demonstration grants account individually for a substantial proportion of all grant funds, we discuss the findings for model demonstration grants more fully than the findings for the other grant types.

B. EXPERIENCE WITH GRANTS

1. Views of the National Review Committee (NRC)

When we interviewed members of the National Review Committee (NRC) in 2002, we found that they shared similar concerns about grants as those of MMCP program staff (Fasciano and Angeles 2003). They perceived that MMCP's grant programs filled a unique niche and

TABLE VII.1

OVERVIEW OF MMCP GRANTS AWARDED FROM 2000 TO MID-2003

Grant Type	Maximum Grant Award	Number of Grants between 2000 and Mid-2003	Approximate Total of Grant Awards between 2000 and Mid-2003
Model demonstration		18	$5,438,000
Full-scale	$750,000[a]	12	4,855,000
Planning	100,000	6	583,000
Best practices/policy studies	$100,000	50	$3,875,000
Health plans		10	814,000
Providers		1	100,000
State agencies		1	100,000
Research organizations		33	2,517,000
Consumer groups		5	344,000
Community integration	$100,000	7	$639,000

Source: MPR Analysis of information provided by CHCS.

[a] The ceiling for model demonstration grants was raised from $500,000 to $750,000 in 2002.

TABLE VII.2

MMCP GRANTS AWARDED, BY LOCATION

	Location			
Grant Type	East	Midwest	West	South
Total	36	9	15	10
Model demonstrations	6	2	4	1
Best practices/policy studies	28	6	10	6
Community integration	2	1	1	3

Source: MPR Analysis of information provided by CHCS.

made possible some innovations in service delivery that would not have developed otherwise. They described the model demonstration grant program as the only one of its type. In the words of one NRC member, the program was doing "something no one else is—investing in purposeful experimentation, innovation at the operational level." But members also were dismayed by the difficulty involved in fostering innovation in Medicaid managed care, even with generous grant funding. Most members agreed that the outcomes of the grant proposals—particularly in the case of the model demonstration grants—were initially disappointing. Opinions were mixed as to whether the caliber of proposals had improved or deteriorated over time.

In the case of the model demonstration grants, NRC members said that the challenge for would-be grantees—typically states and health plans—was to develop new models of service delivery that were innovative yet feasible. To their thinking, the commitment of leadership and replicability were increasingly important criteria for selecting grantees, with diffusion a much more important criterion than innovation. Members supported an expanded role for CHCS staff in encouraging better grant applications. They also noted that, while broad-scale success had not occurred, MMCP was a "social venture capitalist" such that some failure was to be expected.

NRC members were highly enthusiastic about the Center's new strategy that called for linking technical assistance to the grants to enhance the success of the latter. They voiced a primary concern, however, that those not coming forward on their own in search of technical assistance might be less committed to new models of service delivery and that a "good old boys' grantee network" might be evolve. The NRC members suggested that it would be valuable for them to receive more feedback on project outcomes and stressed that broader dissemination of the model grant program's successes and failures would highlight lessons learned.

2. MPR Evaluation Findings on Model Demonstration Grants

MPR's evaluation included 10 model demonstration grants (see Table VII.3) (see Taylor and Gold 2004). The activities undertaken under the grants ranged from initiatives focusing on measuring quality and performance in a state's Medicaid managed care plans to an innovative approach to providing health care to a specific subpopulation. The average award for a full-scale grant was about $375,000, with the average project length about 2.5 years. Five of the grants went to states and another to a private entity that works closely with a state. Three went to health plans and one to an entity sponsoring a primary care case management demonstration.

Of the grantees interviewed, eight described their project accomplishments as very or fairly in line with their proposals' original goals, with three reporting that they had accomplished more than originally proposed. Readers will note that many of the demonstration grantees are the same organizations receiving substantial technical assistance from MMCP.

We rated each grant in terms of its sustainability (see Table VII.4). Four scored high, which meant that the project was still in place and demonstrated strong prospects for sustainability in terms of funding, buy-in, and so forth. The four grant activities included state-based work on school-based health centers, a foundation PCCM program, state plan performance measures, and another state's performance indicator system. The latter two involved states named previously as among the most successful under MMCP. Two additional grants scored medium, which meant that the project, or outgrowths of it, were still in place but that prospects for long-term sustainability were, from what we could discern, less clear. Health plans seemed to have more difficulty than states in sustaining grant-based activities because of fiscal pressures that they experienced at the time when the grant expired. However at least two of the health plan grants appeared to show fairly strong promise for success. The most unsuccessful grantees typically faced staff turnover that impeded their success.

TABLE VII.3

CHARACTERISTICS OF MODEL DEMONSTRATION GRANTS

Grant Title	Organization (type)	Population of Interest	Overall Goal	Project Type	Scale (as of fall 2003)	Desired versus Actual Outcomes
The Children's Comprehensive Care Project (Note: planning grant)	State Department of Health Care Policy and Financing	Children with special health care needs (CSHCN)	To improve care coordination and programs available to children with special needs who are enrolled in Medicaid	Coordination	Four of the 5 state MCOs participated	Outcomes in line with those proposed: improved identification of CSHCN; developed and used protocols for certain conditions
To Support the Transition of Medicaid Beneficiaries with Disabilities in Managed Care	State Public Health Institute (private, though works closely with state)	Persons with disabilities	To promote collaboration between health plans, advocates, and Medicaid (includes increasing plan capacity to serve disabled persons and providing consumer education); promote use of specialists as primary care providers for clients with severe disabilities	Coordination	N/A	Developed consumer education materials; built relationships between organizations that had not worked together in the past; created support groups Project had more difficulty than expected in recruiting disabled persons; strategy of assigning specialists as PCPs did not succeed
To Improve Coordination between School-Based Health Centers and Medicaid Managed Care Delivery Systems	State Department of Human Services	Children and their families	To facilitate collaboration between school-based health centers and Medicaid MCOs in order to improve care for children enrolled in Medicaid managed care	Coordination	Linked 5 school-based health centers with 3 MCOs	Outcomes were very much in line with targets Implemented use of protocols for EPSDT screens and certain conditions; increased rates of immunization and health screens

TABLE VII.3 (continued)

Grant Title	Organization (type)	Population of Interest	Overall Goal	Project Type	Scale (as of fall 2003)	Desired versus Actual Outcomes
Family Maintenance Healthcare Demonstration Project	Health Plan	Children under the supervision of County Child Protective Services	To identify children enrolled in the plan who are under the supervision of child protective services and provide them and their families with case management (beginning with assessments and care plans)	Care delivery	Around 400 children	Outcomes were in line with targets, though project faced some resistance in community as well as from local agencies; able to provide training to provider community and improve coordination among the health plan, schools, and social workers
Reinventing the HMO: The Next Generation of Medicaid Managed Care	Health Plan	Persons with chronic illnesses and disabilities	To improve the primary care coordination of Medicaid beneficiaries with chronic illness and disability at a clinic in the state	Care delivery	Around 1000 patients	Outcomes surpassed expectations; project was able to show decreases in emergency room utilization, hospital utilization, and costs and increases in patient satisfaction
Improving the Care of Persons in a PCCM Rural Setting	Private Foundation	Children with special health care needs, rural populations	To improve screening of enrollees with special needs, better coordinate their care, identify gaps and barriers in system, and improve communication between primary care providers and other providers	Care delivery	Coordination provided for 30 to 35 children in a county The county site has developed resource books and treatment contracts; number of enrollees not specified	Program has been implemented as expected (coordinated care as outlined in proposal), though with a limited numbers of enrollees
Increasing the Use of Self-Help Programs and Mental Health Competencies under Medicaid Managed Care	Health Plan	Persons with mental illness	To introduce a new model of service delivery that focuses on recovery rather than on more traditional treatment approach	Care delivery	Introduced in various health plan locations in four states with varying degrees of success	Staff receptiveness to the recovery model varied from state to state and, as a result, program was difficult to implement; have made headway in some areas

TABLE VII.3 (continued)

Grant Title	Organization (type)	Population of Interest	Overall Goal	Project Type	Scale (as of fall 2003)	Desired versus Actual Outcomes
Implementing a Performance System for Community Children's Behavioral Program	State Department of Social Services	Children with special health care needs	To monitor the quality and services of provided to CSHCN in the children's behavioral program	Performance measurement	N/A	At end of 2003, project had not begun because the state legislature had put the program on hold
Risk-Adjusted Models for Measuring Health Plan Performance	State Department of Health and Mental Hygiene	Medicaid managed care	To measure and monitor plan performance by using encounter data and to determine how best to handle risk adjustment	Performance measurement	N/A	Outcomes were in line with targets; state was still in process of developing performance measures for some conditions
Health Indicator System on Medicaid	State Department of Human Services	Medicaid, with a focus on children with special health care needs and adults with disabilities	To create a Medicaid Health Indicators data archive that includes state and national data on Medicaid; to track utilization, costs, outcomes, and access and satisfaction; to make changes in Medicaid care delivery based on results	Performance measurement	N/A	Outcomes were very much in line with targets Created indicator system and now use data extensively to monitor and make changes in Medicaid delivery

Source: MPR Analysis of grant documents.

TABLE VII.4

PROJECT SUSTAINABILITY AMONG INTERVIEWED GRANTEES

Grant Type	Total Studied	Sustainability Rating			
		None	Low	Medium	High
Model demonstrations	10	2	2	2	4
Best practices (where sustainability is relevant)*	8	4	1	2	1
Community integration	2	--	1	1	--

*Excludes one grantee that could not be reached for an interview.

3. Smaller Grants

Smaller MMCP grants include best practice grants, policy grants, and community integration grants, each with an award up to $100,000. The best practice grants are most similar in intent to the model demonstration grants, though at a much reduced scale. The average size of the best practice grant studied for the evaluation totaled $75,000. Health plans and health systems were the most common type of best practice grantee, although several consumer organizations and a state agency were also awarded best practice grants. The grants produced a variety of outcomes, including improved use of appropriate medications among long-term managed care patients, counseling patients with HIV to improve treatment adherence; and the development of consumer information materials such as brochures and guides. Compared with the full-scale model demonstration grants (nearly half of which had strong prospects for sustainability), best practice grants appeared to have more difficulty in sustaining their project work after the grant period, and many grantees did not take a long-term view of their activities.

In contrast, policy study grants typically culminated in a final paper or report often disseminated through conference presentations, publications in peer-reviewed journals, and/or

postings on the CHCS Web site. Awards averaged $65,000 and lasted 12 months. Most went to research organizations.

The last grant type, the one-time-only community integration grant, was intended to help states respond to the 1999 U.S. Supreme Court decision *Olmstead* v. *L.C.* The average grant totaled about $91,000. We interviewed two grantees and found that one used the grant to begin placing back in the community a small number of individuals who required long-term care and that the other convened organizations interested in long-term care and made recommendations regarding state planning in this area.

4. Use of Technical Assistance to Support Grant Making

Given its new emphasis on technical assistance, CHCS made an effort to work with states on the preparation of their grant applications. The large share of grantees reported that CHCS played a role in developing their project during the application process. According to grantees, CHCS helped shape and hone their projects, often noting that the original idea was too broad or unfocused. Although it is impossible to know exactly how projects would have fared without CHCS' early assistance, successful applicants agreed that the assistance improved their project design

As noted, CHCS also provided many grantees with assistance during the grant period. Assistance took the form of direct support on the grant (e.g., a site visit) or more general CHCS activities (e.g., the Quality Summit). All model demonstration grantees received such assistance, though only about half of the best practice grantees reported the receipt of assistance. In general, grantees that did not receive assistance did not see CHCS in as favorable a light as those grantees that did receive assistance. In fact, they reported that they would have liked to have received assistance and guidance. (As might be expected, policy study grantees were an exception.) Given that relatively most of the grantees, particularly the large grantees, received assistance, our

ability to discern how much the assistance fostered grantee success is limited. In general, however, organizations receiving little or no assistance seemed less likely to sustain their projects beyond the funding period. For example, among the eight best practice grants for which sustainability was relevant, five demonstrated low prospects for sustainability, four of which reported receiving too little assistance from CHCS and/or a decline in support from CHCS toward the end of the project. Grantee responses could mean either that CHCS "gave up" on grantees with little potential for success and thus put their energy elsewhere or that CHCS needs to work more closely with grantees toward the end of the grant period to make sure that they have carefully considered how their projects might be continued and/or institutionalized within their organization.

5. Strengths and Weaknesses

The strengths of CHCS most frequently cited by grantees were all independent of grant making and included CHCS' staff, the networking opportunities created by the Center, and CHCS' unique role as an organization focused on improving Medicaid managed care. A particular strength of CHCS' grant making underscored by grantees was the sense of accountability that the Center lent to its grant program. Several noted that while CHCS is fairly flexible in responding to grant constraints, it is nonetheless known for its high standards; grantees recognize that they must produce results when they receive a CHCS grant. Grantees' suggestions for the grant program include improving grants administration (e.g., making reporting requirements less burdensome and reducing the time between application and awards), improving relationships with grantees, and ensuring that those relationships continue beyond the grant period. To the extent that the call for improvements reflects problems, difficulties seem to be the exception rather than the rule.

C. SUMMARY OF FINDINGS

The findings reported here support MMCP's thrust toward leveraging grants with technical assistance. Core audiences view each of these as very important and those receiving both were particularly positive. These findings suggest that MMCP's move to integrate grant making with technical assistance is feasible. But making grants less available in the future and greatly limiting large grants could have opportunity costs. Some grantees that made substantial progress under MMCP used the support of larger grants to help them succeed. Such grants appear particularly relevant to states, which have had a longer history with MMCP and which can use grants to develop structures that then can be funded through ongoing operations. This situation is less available to health plans. Few alternative sources of funding are available for large projects in Medicaid managed care. Further, outside funding appears important in helping some of the target audiences build the infrastructure needed to support the changes that they seek to introduce.

VIII. AUDIENCE VIEWS OF MMCP'S STRENGTHS AND WEAKNESSES AND WILLINGNESS TO SUPPORT THE PROGRAM

At least three issues are important to RWJF in assessing a program such as MMCP: (1) whether the program addresses a need and therefore has merit; (2) how the need addressed by the program relates to the foundation's current priorities; and (3) the degree of importance of RWJF's support of the activity versus the applicants' reliance on other available funding sources. We direct the evaluation primarily to the first issue but nonetheless also capture some information relevant to the third. We also discuss additional findings, not previously presented, that are relevant to each of the issues and leave it to foundation staff to judge MMCP's relative priority vis-a-vis other demands on resources.

A. PERCEIVED PROGRAM NEED AND MERIT

Core audiences strongly support MMCP's work and the program's potential for further work. In addition, the audiences agree that work in the area of Medicaid managed care will continue to be of importance to them. We summarize what we heard from each core audience.

States. State directors and senior Medicaid staff are largely positive about MMCP (Draper and Gold 2004). Among state Medicaid directors, three strengths stand out. The first, discussed by nearly 40 percent of those interviewed, relates to the caliber, competency, vision, and overall knowledge of CHCS staff. The second, which was important to just under 40 percent of state directors, pertains to the value of CHCS as an informational, technical, and (sometimes) funding resource. The third major strength, cited by more than one-quarter of respondents, relates to CHCS' understanding of state issues, particularly the Center's ability to reach out and facilitate states' learning from each others' experiences. Many directors said that they could not identify any weaknesses; those who did identify weaknesses were mostly likely to cite CHCS' limited

resources, a factor mentioned by about 15 percent of directors. Most commonly, these directors were referring to CHCS' limited staff and enormous agenda. The other weakness most likely to be cited (10 percent of directors) was directors' lack of awareness of CHCS and/or its activities. When asked for improvements, about one in five directors recommended that CHCS should work toward increasing awareness and/or use of its activities and resources.

In a second area of discussion, state directors addressed the future relevance of work on Medicaid managed care. While the viability and path of managed care differs widely across states, state directors generally seemed to assume that managed care will persist in some form into the future. Among new directors interviewed in 2004, for example, four expected worsening budget climates and saw managed care as an important vehicle for addressing fiscal constraints. One of the two states that reassessed its involvement in managed care saw a continued need for care coordination and disease management, among other items, in its quest for cost containment.

In our 2003 survey, Medicaid directors agreed that they were facing several challenges in implementing managed care, but they were about evenly split on the extent to which the challenges were new versus a continuation of existing challenges. As one noted, "The budget crisis has been around ever since I've been involved in Medicaid." Another remarked, "We got into managed care because of the budget crisis." Directors did, however, exhibit both an increasing sense of urgency or intensity with respect to the issues and a perception that working with providers to address their concerns had grown more difficult. Several directors said that a major factor that might influence their involvement in CHCS-supported activities would be the ultimate effect of the change on state costs under the program. But the directors also saw opportunities in the current environment and expressed interest in prudent purchasing and quality improvement as ways to maximize the value of their investment or even save money.

Health Plans. Given that the health plan survey involved a mail/telephone follow-up rather than open-ended interviews, our assessment of health plans' views of CHCS were somewhat more limited than that of the states' views. The survey results show that CHCS raised plans' awareness of its work, particularly among Medicaid-dominant plans. In addition, CHCS engaged about 30 percent or more of responding plans in one of more of its activities; those involved in the activities tended to rate them favorably. Health plans' repeated interactions with MMCP reinforces their perceptions of value as do the comments made by plans interviewed for the BCAP case studies. Results from the survey also suggest several areas for improvement. Perhaps the most notable area relates to many plans' inability to rate a number of MMCP activities, a reflection of the commercial plans' limited familiarity with CHCS. Yet, even a sizeable portion of Medicaid-dominant plans (generally one-third or more) could not rate any CHCS activity or area of emphasis.

When asked directly (in the form of an open-ended survey question) for suggestions about how to strengthen CHCS' work with the three core audiences, plans were most likely to suggest that CHCS should engage in more direct outreach to the plans, including, some suggested, contacting plans' medical directors individually (nine respondents). Other recommendations called for facilitating "cross-conversations" between states and plans and helping "build bridges of communications" that span the policy and operational level (four respondents); involving more states, especially Medicaid directors, in MMCP and integrating state and CHCS activities on a day-to-day basis (three respondents); focusing (or continuing to focus) on disease management and disabled populations (three respondents); and providing more technical assistance to states and plans (three respondents). Other recommendations (by fewer plans) focused on increasing the involvement of others (e.g., federal participants, SCHIP, providers,

consumers), making grater use of return-on-investment models, and providing a five-day training class on leadership.

We did not ask plans about the likelihood of their continued work in Medicaid managed care. However, given that MMCP works most closely with Medicaid-dominant plans, for which Medicaid is a major source or the major source of revenue, we would expect that such plans would work with states to adapt their systems as needed to accommodate program changes. That is, many of these organizations probably are committed for the long term.

Consumer Groups. Like the other two core audiences, consumer groups appear to view MMCP as a very important resource. Facing more limited resources than states or health plans, consumer groups see CHCS as a source of grant funds, technical assistance, and training—all of which are hard to come by. When asked about their recommendations, almost half of the consumer groups interviewed for the evaluation wanted CHCS to increase the activities offered to consumer or advocacy groups (seven respondents). Consumer groups also called for more grant activity, including targeted grant making (three respondents), as well as increased outreach activities to inform people about CHCS. (two respondents). Whatever the direction in which states take their program, consumers will likely continue to be interested in technical assistance to ensure that patients know how to use the managed care system and participate in its design.

B. WOULD CORE AUDIENCES CONTRIBUTE TO THE COSTS OF MMCP?

1. Why the Issue Is Important

Obviously, foundations have limited resources. For programs seeking renewal, the importance of RWJF's continued support is particularly relevant; yet, RWJF's ongoing support typically limits the foundation's ability to initiate activities in other areas. Often, RWJF views its role as time-limited until, for example, an idea's merit is demonstrated and thus lends itself to replication by others or institutionalization without the foundation's continued support.

Programs such as MMCP, however, involve technical assistance and thus capacity building. While investments in capacity building may be time-limited, the need for the building of infrastructure often is ongoing. Hence, we are unable to specify the time frame for which ongoing RWJF support is reasonable.

Though our evaluation focused primarily on the merit of MMCP, RWJF encouraged us to look also at the issue of MMCP's viability in the absence of RWJF support. Based on the results, both of our surveys and of a study funded through a related grant, we review what we learned from the core audiences about their ability to contribute to the costs of MMCP.

Findings from both analyses need to be viewed in context. MMCP is a resource-intensive effort. MMCP has spent or will spend about $30 million from its last authorization (2002), with CHCS now stretching those resources over five years. Many of the technical assistance activities are resource-intensive and occur over a long period. CHCS now seeks to stretch these funds by requiring participants to share some of the costs (e.g., travel). It is also restricting grants to activities that integrate technical assistance, thus generating synergy. Further, it is dramatically reducing grant amounts. In the most recent initiative on the business case for quality, for example, grantees received only $10,000 with the understanding that they would contribute substantial in-kind resources.

Our findings suggest that core audiences demonstrating the greatest progress under MMCP had received substantial technical, and sometimes financial, support from the program or other external sources. While our findings do not necessarily establish causation, they do suggest that a program such as MMCP is likely to require funding to provide extensive assistance and support to cover audiences.

2. What Core Audiences Told Us

Our efforts to capture data from the core audiences on their ability to contribute to the costs of technical assistance focused exclusively on states and health plans; the data, limited in nature, came primarily from responses to our surveys. We designed our data collection effort with the aim of asking questions about the merit of MMCP versus the need for RWJF funding. However, in structuring our questions about financial support, we took care not to query respondents in a way that might lead them to view the program as time-limited or in jeopardy. We did not want to bias responses with participants' concerns that funding for the program could be any more in doubt than is usual when any program is undergoing an evaluation.

Findings from State Director Interviews. The survey findings suggest that, while states might be able to contribute some amount toward the cost of attending Purchasing Institutes or the cost of receiving individual technical assistance of the type provided by MMCP, they might be limited in their ability to make the needed contributions and thus have to limit their participation in MMCP activities. Further, it is possible that, if the states with new state Medicaid directors are typical, the fiscal environment probably became more rather than less constrained between 2003 and 2004. The specific findings follow:

- Among state Medicaid director survey respondents who reported their states' attendance at a Purchasing Institute, 54 percent said that they were willing to pay a fee; 17 percent said that they were not willing to pay a fee; and 29 percent said that they might be willing to pay a fee. A director willing to pay said, "If we were choosing priorities, the Purchasing Institute would be at or just below the top of the list." Those not willing to pay frequently pointed to budget constraints. A number added that, while they might have been willing to pay a fee at one time, they lack the funds to do so now. Factors in their decisions included interest in/relevance of the topic, budget constraints, and fee amount (Draper and Gold 2004).[42]

[42] Directors in states that had not yet attended a Purchasing Institute in 2003 pointed to budget constraints and state travel restrictions, along with lack of staff/staff workload, as common reasons for nonattendance, with lack of awareness, limited/no managed care purchasing in the state, and lack of need as other reasons.

- All five new directors whose states participated in the November 2003 Purchasing Institute noted that, for two reasons, a required fee would have made their participation difficult: first, resources are constrained; and, second, the approval process for travel that involves a registration fee is particularly complicated. Three directors noted that fees of a few hundred dollars per participant might be possible but that they would probably send fewer staff if a fee were charged (Howell and White 2004).[43]

- The 11 states that reported receiving on-site, one-on-one technical assistance generally said that they would be willing to pay for such assistance; seven said that it would be willing to pay, one said that it would not be willing to pay, and the rest said that they did not know. However, not all states willing to pay for technical assistance believed that they would be able to do so; of the seven, four said that they would be able to pay, two said that they would not be able to pay, and one did not know. (The results show that roughly a third of the states that received such assistance would pay, but the numbers are so small that the findings should be regarded with caution.)

The above findings suggest that directors perceive MMCP as a valuable resource. They would like to support the program, but their ability to do so may be limited by restrictions on state finances, by the administrative approvals necessary to authorize travel, or by other factors. Moreover, the constraints were, if anything, growing more rather than less stringent.

Findings from Health Plans. Health plans participating in Medicaid are diverse. By and large, it appears that Medicaid-dominant plans place a greater value on MMCP than do commercial plans; in fact, the MCMP has reached a greater number of Medicaid-dominant versus commercial plans. The former plans span a wide spectrum that includes some for-profit plans operated by firms specializing in the Medicaid market and a broad variety of nonprofit plans of diverse sponsorship that may include community health centers, hospital systems, local governments, community organizations, or others. With this diversity, the financial situation of Medicaid-dominant plans and the plans' access to capital are likely to vary substantially. Unless they have other sources of income, Medicaid-dominant plans must rely on capitation fees as their

[43] The Purchasing Institute model encourages states to send teams that include directors and several managers who can follow through on implementing change.

major source of patient care revenue. The generosity of these fees varies across states, though payments historically have been lower in Medicaid practices than in Medicare practices.[44]

Despite variations in their financial status, Medicaid health plans that already were experienced with BCAP would apparently be willing to contribute to the costs of future BCAP participation. According to MMCP practice, if CHCS accepted a plan for participation in a workgroup/workshop or Quality Summit, the Center paid for the time and travel costs of two staff members. To gauge the likelihood that plans would pay for their own participation in future activities, we asked whether plans would be willing to pay for staff time and travel for participation in MMCP activities. Among the 38 plans that reported participating in the workgroups, 79 percent said that they would be willing to pay to participate in future workgroups, and 89 percent said they would be willing to pay to participate in workshops or the Quality Summit. (The latter involve a single session versus the workgroups, which entail several sessions over nine to 12 months.) Almost all those responding negatively attributed their response to plans' budget constraints or limited finances, not to the perceived usefulness of the activities. It is important to bear in mind, however, the hypothetical nature of the question and the lack of information on how much plans would be willing to pay.

3. What We Found in a Related Analysis

In addition to underwriting MMCP, RWJF supported technical assistance to purchasers in other programs, including the National Health Care Purchasing Institute (NHCPI), which focused on Medicare and commercial payers (see Angeles and Gold 2003). While that program no longer exists, RWJF asked that we use part of the available funds to evaluate the NHCPI in

[44] For additional analysis, see John Holahan and Shinobu Suzuki, "Medicaid Managed Care Payment Methods and Capitation Rates in 2001" *Health Affairs* 22(1):204-218, January/February 2003. Note that payment rates for 2001 were set in 2000 and were likely to be influenced by the then–positive state fiscal climate.

order to develop better insight into the technical assistance needs in the Medicare and Medicaid payer markets and the capabilities of the federal government and states to address those needs. To develop such an analysis, we contracted with Ruth Martin (and her colleague Mary Kenneson). We review the findings related to state purchasing under Medicaid (Martin and Kenneson August 2004).[45] The consultants based their findings largely on interviews with 10 individuals who were former Medicaid directors in states at the forefront of Medicaid managed care; consultants who have assisted states in designing and implementing voluntary and mandatory Medicaid managed care programs; and researchers who have conducted evaluations of Medicaid demonstrations. Readers should keep in mind (1) that interviewees tended to be former administrators and (2) that we did not ask interviewees to focus specifically on the clinical areas that have been dominant in MMCP in recent years.

Perceived Technical Assistance Needs. Informants were virtually unanimous in saying that state staff could use technical assistance and training in developing and monitoring managed care contracts—whether contracts covered disease management and care management for the Medicaid fee-for-service populations, primary care case management, or full-risk managed care. They also saw a need for technical assistance in the development of actuarially sound payment rates and risk-sharing arrangements that matched the managed care contracts. Informants also concluded that state Medicaid agencies would benefit from technical assistance directed at

[45] Martin and Kenneson also interviewed CMS staff about their technical assistance needs for Medicare and Medicaid. They found that CMS was much more focused on the Medicare program than on the Medicaid program because of (1) the Bush Administration's policy stance on restricting the federal role relative to states on Medicaid and (2) the demands on CMS that resulted from the passage of the Medicare Prescription Drug Improvement and Modernization Act of 2003. Given the philosophy that directs devolution of responsibility for Medicaid operations strictly to the states, the federal government has reduced the technical assistance budget of the CMS Center for Medicaid and State Operations. As required by the Balanced Budget Act of 1997, federal Medicaid interests focused mainly on managed care rate setting and risk adjustment and support to regional office staff in evaluating Medicaid managed care contracts and actuarially sound capitation rates. CMS' Office of Research, Development and Information was interested in conducting more in-depth evaluations of several Medicaid managed care demonstrations and of the Medicaid fee-for-service demonstrations.

establishing more timely and accurate eligibility determinations and related health plan enrollment, development of managed care models for rural areas, and development of strategies to attract and retain managed care plans. They also saw a need to create a forum for information exchange among representatives of CMS, state Medicaid agencies, and Medicaid managed care plans.

How Convening and Technical Assistance Services Are Procured. Like the federal government, states operate according to carefully specified budgeting processes that require programs to identify and budget for technical assistance and program support contracts several months in advance of the start of their respective fiscal years. The highly structured procurement process for technical assistance and consulting services usually requires the issuance of a request for proposal, a formal review committee's evaluation of technical and business proposals, and then award of a contract. The protracted timelines for these activities often preclude states from contracting for immediately needed technical assistance. Sole-source contracting provisions afford some relief, allowing agencies to procure a limited amount of technical assistance (e.g., $10,000 to $25,000) from uniquely qualified consulting firms and other organizations. Some states have structured their major Medicaid contracts (e.g., Medicaid managed information systems contracts, enrollment broker contracts, and/or external quality review organization contracts) to include "other consulting technical assistance services as needed by the agency." In some cases, in parallel with the federal government, states have entered into indefinite delivery/indefinite quantity (ID/IQ) contracts with large consulting firms that they can tap as needed.

Barriers to Obtaining Assistance. Interviewees said that state (and federal) staff often are unable to secure relatively small dollar amounts for staff training and educational activities, such as participation in conferences and workshops and purchase of publications. In addition, budget

restrictions on staff travel in recent years have prevented staff from attending conferences, even with a conference fee waiver. Interviewees also said that many states are not well equipped to apply for foundation grant funding in that they lack readily available, skilled grant writers. As a result, states often do not apply for grants of less than $200,000 to $250,000 because of the effort involved in writing the grant application and managing the grant process.

Technical Assistance Preferences. Interviewees did not specify a preferred mode of technical assistance, though they indicated that conferences and workshops, such as those sponsored by the National Association of State Medicaid Directors and the National Academy of State Health Policy, had proven useful.[46] They were interested in workshops that provide unbiased insights into the trends, issues, and innovations in government and private sector fee-for-service and managed care, particularly given state legislative interest in strategies for controlling Medicaid costs. They did not deem written materials on topics such as benefit design, rate setting, and quality improvement as sufficient to guide most state agency staff in developing and implementing initiatives around these matters on their own. Interviewees concluded that hands-on technical assistance from experienced consultants is often required to implement state-specific programs and systems.

Value of Foundation-Supported Technical Assistance. Informants generally agreed that the health policy and operations sector views foundations as unbiased members of the health field. They also noted that foundation-supported activities have earned respect for their thoroughness and sound research base. Informants said that foundations play an important role in supporting the interests of populations that might go overlooked by government or private

[46] We deliberately asked Martin and Kenneson to avoid current Medicaid directors and staff as we already were interviewing them for the evaluation. We similarly asked that they not probe specifically on activities that CHCS or MMCP convenes but rather consider more general areas of need and preferences.

sources of health care funding. Thus, foundations can be a catalyst for health issues that affect a wide range of stakeholders. In addition, one informant who was a former state Medicaid director and provided consultation to an RWJF program office, pointed out that foundation-supported technical assistance can provide two- to three-day "on the fly" technical assistance to state Medicaid agencies. Such technical assistance can take the form of briefings to legislative and executive staff on Medicaid issues, orientations for new state Medicaid agency directors and key staff, and brainstorming sessions with agency staff on approaches to improving program design and operations.

Strength of Foundation Funding. Interviewees identified two principle strengths of foundation funding. First, foundations can bring resources to bear on issues and populations that federal or state agencies otherwise would not attend to because of limited resources and competing priorities—"big picture" health policy issues that affect multiple stakeholder interests; topics that are important but tangential to staff's immediate responsibilities; and support of special populations that lack sufficient advocacy to attract policymakers' attention. Second, foundations undertake unbiased research and organize forums that address difficult-to-resolve issues arising out of conflicting special interests.

Based on the information they gathered, Martin and Kenneson (2004b) recommended three potential opportunities for foundation funding, whether through RWJF or other foundations and/or program office business development:

1. ***Convening and technical assistance, including support on specific technical issues, "on-the-fly" assistance, development of written materials and training, state-specific hands-on assistance, and structured cooperative technical assistance such as the BCAP models.*** Topics of interest include basic principles of managed care operations, capitation rate setting and risk adjustment, health plan contract review and readiness assessment, health plan performance monitoring, quality improvement, Medicare/Medicaid program interfaces, chronic care coordination and disease management, and coordination and management of pharmacy benefits. Foundation

funding would be needed to initiate development and to support organizations that could not afford to attend technical assistance sessions. Ongoing support would depend on whether agencies have budgeted monies for such efforts and whether services can be priced in line with budgets.

2. ***Creation of forums for Medicaid managed care stakeholder collaboration.*** The forums would bring together disparate organizations such as CMS, state Medicaid agencies, other federal and state agencies involved in managed care (e.g., child welfare agencies, Centers for Disease Control and Prevention (CDC), health plans, providers, consumer advocates, and companies that provide services related to managed care programs, such as enrollment brokers and external quality review organizations). Because perceived neutrality and lack of bias are necessary for effectiveness, such forums would best be funded by one or more foundations.

3. **Creation of a Medicaid HEDIS data warehouse.**[47] The warehouse would track trends by region, type of Medicaid user, and so forth, especially if such data collection did not compete with the National Committee for Quality Assurance (NCQA) QualityCompass Reports. Foundation funding would be required to set up a warehouse but would allow some opportunity to fund ongoing operations through state and health plan subscriptions.

Martin and Kenneson (2004b) went on to consider alternative funding models that could support activities beyond the traditional MMCP-type model involving a foundation-funded national program office. Finding the literature thin, they developed three alternative model concepts: (1) an internal model in which the foundation would establish and operate its own technical assistance office; (2) a collaborative model in which several foundations would fund an independent organization to function as the technical assistance office; and (3) a "venture capital" model in which the foundation would provide the initial capital to set up an independent center that would then develop and implement a business plan that identifies several sources of revenue for support of technical assistance. The consultants also conducted interviews with staff in organizations involved in revenue diversification to learn about potential revenue sources from other foundations, the federal government, product sales, membership fees, contributions

[47] At one time, the national Medicaid directors collaborated with NCQA to support such a warehouse, but we are uncertain as to its current status.

solicited from industry, and in-kind contributions. Interviewees emphasized that any such effort must respect the context of a program's office mission, taking into consideration potential conflicts of interest with grant programs that the organization may operate on behalf of RWJF or others. Organizations that solicit proposals for grants, for example, cannot charge potential grantees for technical assistance. Interviewees also stressed the importance of a business plan that clearly identifies the organization's mission, business environment, growth strategy and plan for implementing that strategy, and a financial plan.

C. SUMMARY OF FINDINGS

This chapter discussed several findings relevant to RWJF's ultimate decision about continued support of the MCCP. From the perspective of need and value, the evaluation shows MMCP's core audiences perceive that the program's mission is important and that its technical assistance resources are strong. The core audiences expect that Medicaid managed care and the types of issues addressed by MMCP will continue to be important. Given the current environment in which Medicaid managed care operates, however, two issues will dominate: "cost-value" and flexibility to modify programs in response to fiscal pressures. From our perspective, we see a risk that financially strapped legislators will expect more from managed care, quality improvement, and systems design than will be delivered. But we also believe that states have few alternative models; as a number of states noted, the alternative of reverting to full fee-for-service payment is not attractive to many states from either a fiscal or a care delivery perspective.

The findings on the issue of fiscal support are mixed. On the one hand, states and health plans that have availed themselves of MMCP attest to the program's importance and would be willing to help underwrite the activities in which they participate. On the other hand, MMCP experience indicates that the funding needed to generate and sustain improvements is large and

that the ability of states and plans to allocate funds to improvements is questionable. Further, requiring a fiscal contribution may limit program outcomes if it reduces participation. State administrative procedures make it difficult for many states to contract for smaller, short-term support on a flexible basis, though they can and do enter into large, long-term contracts for assistance with major program activities. Health plans are bound by fewer of these limitations, but their access to capital frequently is limited, and many rely on a monthly capitation funding stream that is both tight and poorly suited to generating large amounts of capital for investment. Given the pressures of the market to generate short-term earnings, access to capital can be an issue even for public companies. Consumer groups have little money of their own to support interventions, and experience suggests that many funders do not see such support as a priority. It also appears that federal support for technical assistance targeted to Medicaid issues will likely be limited because of policies that assign such issues to the purview of states. However, to the extent that state priorities coincide with federal priorities associated with implementing the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), some federal support might materialize. Pharmaceutical benefits and dual eligibles would appear to be the areas of greatest overlap.

IX. SUMMARY OF FINDINGS AND CONCLUSIONS

This chapter addresses one of the most important questions from the evaluation: What do the findings say about the value, importance, and accomplishments that RWJF might expect from future funding of MMCP, and, given what we learned about MMCP's strengths, weaknesses, and potential for self-support, what are the most important activity areas to support? To provide a basis for answering this question, we first review the major findings from the evaluation and then analyze them.

A. OVERVIEW OF MAJOR FINDINGS

The evaluation set out to answer seven questions critical to consideration of MMCP's value and associated implications for program renewal. We review, in turn, the major findings for each question.

1. What Does MMCP Aim to Do, and How Has the Program Evolved Over Its History?

The Robert Wood Johnson Foundation established MMCP in 1995. The foundation took advantage of Medicaid's shift to managed care to create a program directed at improving health care delivery for vulnerable populations served by Medicaid. Over time, MMCP evolved from a traditional grant program focused on chronically ill populations to a major program of technical assistance that aims to work with states, health plans, and consumers to encourage "cutting-edge" innovations. MMCP seeks to generate improvements in the purchase of high-quality, cost-effective care through Medicaid managed care organizations that themselves focus on quality improvement.

MMCP, however, is not a static program. Though it remains focused for the most part on Medicaid managed care, the program has aimed to respond to what CHCS sees as a fluid environment and changing set of funding priorities. To that end, value-based purchasing and

quality improvement have become MMCP's dominant focus, subsuming its earlier and more diverse work that also addressed issues such as rate setting and risk adjustment. Technical assistance has gradually come to dominate what originally was a grant program. Increasingly MMCP has integrated grants and technical assistance. At this point it is focused almost entirely on providing a variety of forms of technical support to help states and health plans achieve certain ends, with, at most, limited grants that assume substantial in-kind investment from participants. MMCP also continues to trade off a broad-based focus on quality improvement in Medicaid managed care and a targeted focus on improvements for the minority of enrollees with large and complex needs. MMCP's host organization, CHCS, also has evolved from an organization solely defined by MMCP to one that, with MMCP as its core, is branching out in several areas, many of which are synergistic with MMCP's goals. Typically involving funding from other foundations, these activities also have allowed CHCS to experiment with modifying its essential MMCP form. A good example are the geographically focused models for BCAP that bring together core audiences and potentially add providers to the mix of BCAP participants.

As RWJF considers future support of MMCP, it would be useful to analyze foundation views of the program's purpose. Presumably, the foundation would consider certain goals and program elements part of a long-term commitment to developing widespread sustainable change. But RWJF also needs to recognize that CHCS staff see flexibility as an important program feature that allows the program to continue to innovate, address emerging issues, and achieve short-term gains. Hence, allowing some degree of continued flexibility is likely to be important to success. As related programs and several funding sources increase CHCS' complexity, the foundation also might find it valuable to consider when MMCP needs a clear identity and when part of its role is to create synergy among diverse activities and programs. Explicit discussions

of these issues will make it easier for RWJF to hold MMCP accountable for what both the foundation and MMCP agree are the most important goals and uses of foundation funding.

2. Is MMCP Regarded As a Valuable Resource by Its Key Audiences—States, Plans, and Consumers—and What Is Its General Reputation Among Stakeholders?

The results of national surveys of each audience are positive. Core audiences, as well as others with an interest in Medicaid managed care, are generally aware of CHCS and its work in the managed care arena. While a variety of sources of information on Medicaid managed care are available to the core audiences, a large share of the surveyed audiences perceive that CHCS provides something that others do not. MMCP's activities and programs have reached at least 75 percent of states through their participation in Purchasing Institutes, grants, and/or technical assistance activities. MMCP's effort to reach health plans, a newer audience, has led to the participation of about 42 percent of Medicaid managed care plans in one or more of the plan-focused MMCP activities (BCAP workgroups or workshops, Quality Summit, grants, or technical assistance) through 2003. Participants overwhelmingly rate the activities as excellent or good. Awareness levels among groups in the "national audience" (CMS staff, consumer groups, researchers, and so forth) are similarly high; consumer groups also rate the focus of Consumer Action grants very positively.

The evaluation reveals some areas of potential weakness. First, MMCP generally serves Medicaid–dominant plans much more than commercial plans, with the former much more aware of MMCP, more likely to participate in program activities, and much more likely to view the resources as unique.[48] While it could be valuable for MMCP to reach out more to commercial plans to encourage them to focus more specifically on the needs of the Medicaid population,

[48] MMCP has reached some commercial plans that are not Medicaid-dominant but have a relatively large share of Medicaid enrollees. They may be an exception that offers more potential.

CHCS would probably not succeed in reaching these plans given their commercial focus and the other resources available to them. MMCP's current plan audience thus appears to be the most important one for the program. Second, MMCP awareness levels are relatively uneven across audiences; CHCS needs to do a better job of conveying to its core audiences the range of activities in which it is engaged and how the activities are interrelated. The findings also point out some areas of opportunity. In particular, MMCP might want to consider closer involvement with CMS, both in central and regional offices; central/regional staff view states as the responsible party for Medicaid and demonstrate a strong interest in MMCP's work.

3. Has MMCP Helped States Become Better Value-Based Purchasers, and Are Changes Likely to Endure?

This is one of three questions essential to judging MMCP's success—determining whether the program makes a difference, especially in tangible ways that ultimately affect the people served by Medicaid managed care. The findings with respect to states are encouraging. Half of all Medicaid program directors said that they made concrete improvements in their Medicaid managed care program as a result of their participation in MMCP. To an extent, these changes reflected difficult-to-prove intangibles, such as validation of state activities, ideas, and support. But we also found evidence that at least 10 states made concrete substantive improvements in their Medicaid managed care programs as a result of activities and interactions with MMCP, all but one of which was implemented and remained in place as of fall 2004. Generating these improvements required substantial investment by MMCP—each state had participated in at least one Purchasing Institute, six received on-site technical assistance, and eight received program grants, including five states that were awarded the larger model demonstration grants. Strong support of the state Medicaid director was critical to many state successes, although changes endured even after leadership turnover if directors had succeeded in institutionalizing change.

While the "new crop" of Medicaid directors supports the program, the findings indicate that CHCS needs to be much more proactive in engaging these directors in MMCP early in their tenure.

Many forces influence the sophistication of state purchasing, but findings from existing national surveys (e.g., Landon et al. 2004) show that states have become more sophisticated purchasers over the period in which MMCP has been operational. Further, our analysis suggests that a variety of states view MMCP as relevant. While MMCP targets the more sophisticated states, those that respond to MMCP most successfully (i.e., make changes) span the spectrum of sophistication but demonstrate at least a moderate level of sophistication in Medicaid managed care and risk-based strategies. The implication is that MMCP has the potential to help states at many levels of sophistication and that opportunistic targeting, such as that employed by CHCS, can have merit. But the findings also highlight the ongoing challenges faced by states in their efforts to improve their Medicaid managed care programs. As directors see it, the greatest challenges lie in attracting and maintaining plan participation, operating within today's state economic climate, dealing with low capitation rates/provider resistance, and meeting the burden of federal requirements. The economic and budgetary climates influence all but the last challenge, particularly as the federal government considers how to respond to deficit and fiscal pressures. Yet, such a climate can also create opportunities for MMCP as fiscal stress reinforces the search for value and value-based purchasing.

4. Has MMCP Helped Health Plans Improve the Care They Provide, and Are Changes Likely to Endure?

The evaluation findings are relatively positive but highlight significant remaining challenges. MMCP's BCAP-related activities (the workgroups, workshops, Quality Summits, and toolkits) reached a substantial share of plans that credit the activities with improving the way

they deliver care. When we looked in depth at plans receiving the most intensive support (as a result of participation in BCAP workgroups), we found that the majority of plans in each workgroup succeeded in implementing change, most of which appeared to be positioned to endure for the long term. Plans also reported that BCAP had changed the way they think and led to other plan changes. But, even with measurement as a core part of the rapid-cycle model, substantially fewer plans were able to track the outcomes of their interventions, and experience with process measures varied across BCAPs. When logic models for intervention and measurement were absent, plans were most likely to struggle. MMCP's BCAP staff still appear to be grappling with how best to generate measurements critical to demonstrating plans' success. Findings also show that MMCP's success in working with plans takes substantial investment—both from MMCP in the way of technical assistance resources and from plans in the way of investments of staff time and developmental resources. Plans that faltered under BCAPs often experienced turnover in leadership and/or staff and adverse financial circumstances. Among the major barriers to improving care, surveyed plans cited the state economic climate (85 percent), low capitation rates (77 percent), and restrictions on state funds available to finance plans' costs for action needed to improve care (65 percent). Not surprisingly, plans that achieved substantial progress in their work with MMCP benefited from a significant investment both external and internal to the plan.

5. What Are the Accomplishments Under the Consumer Action Agenda, and Have Grants Been Effective in Moving It Forward?

The findings with respect to consumers under MMCP are troubling. While consumer groups are specified as the program's third core audience, few MMCP resources are directed to consumer support. Our analysis indicates that, even though Consumer Action grants were small, they earned high marks from consumer groups, which identified few other sources of support for

the activities funded under MMCP. Grantees accomplished a lot for relatively little money, but the grants have left little mark on the environment, with grants too small, too localized, and of too short duration to produce a lasting effect on consumers' and family members' capacity to navigate publicly financed managed care or to have a formal role in designing, implementing, and monitoring managed care programs. With respect to consumers, MMCP's funding has not followed its rhetoric, reinforcing early concerns about "tokenism" expressed by some consumer groups. Nevertheless, MMCP's priorities may be appropriate given the realities of political processes and the interest in observable payoffs from foundation investments. We would argue, however, that CHCS (and RWJF) owes it to consumers to be more forthright about what MMCP offers them and why.

6. What Have Been the Respective Contributions of Grants and Direct Technical Assistance to MMCP's Effectiveness, And Does Leveraging Grants with Technical Assistance Work Better Than Awarding Grants Independently Through Solicitations?

The evaluation findings support MMCP's efforts to leverage grants with technical assistance. Core audiences viewed both grants and technical assistance as highly important. (Health plans, with less grant experience, may be an exception.) Those receiving grant support and technical assistance were particularly positive. Further, many states that made notable progress under MMCP benefited from both types of support. Though MMCP is moving toward a more exclusive reliance on smaller grants, some organizations that made substantial progress under MMCP used larger grants to help them succeed. Such grants appear particularly relevant to states, which, as compared with the other core audiences, had more of a history with MMCP and used the grants to develop structures subsequently funded through ongoing operations. Health plans, in contrast, had less experience with grants and may have had a harder time than states in maintaining activities after the grant period. MMCP has found that even a small grant can convey a sense of accountability and credibility. But it still might want to retain some

capacity to award larger grants particularly to states when such grants are important to the long-term success of planned changes and have leadership support but no other ready access to needed investment capital.

7. Would MMCP Users Be Willing to Contribute to the Costs of Assistance Provided by CHCS, And Under What Conditions?

Whether technical assistance is forthcoming is likely to reflect both the perceived value of the support provided by MMCP and users' willingness and ability to contribute toward its cost. The evaluation findings are substantially more positive on the perceived value of assistance and the willingness to pay for it than on users' ability to pay.

From the perspective of need and value, the evaluation findings show that MMCP's audiences view the program's focus as important and the technical assistance resources as strong. The audiences see Medicaid managed care and assistance with the types of issues addressed by MMCP to be of continuing importance. The current environment, however, reinforces the importance placed on both the "cost-value" issue and the flexibility to modify programs in response to fiscal pressures. From our perspective, we see a risk that legislators will expect more from managed care, quality improvement, and systems design than can be delivered. Yet states are likely to continue to pursue variants of managed care because the alternative, returning to the traditional unmanaged fee-for-service system, is not attractive, from either a fiscal perspective or a care delivery perspective.

The findings on the issue of financial support are mixed. On the one hand, states and health plans that have participated in MMCP view the program favorably and would be willing to contribute to the costs of the activities in which they participate. On the other hand, MMCP experience indicates that the amount of money needed to generate and sustain improvements is large and it is unlikely that users would be able to fund much of this cost. In addition, required

contributions could detract from program outcomes if their design discourages participation. State administrative procedures make it difficult for many states to contract for smaller, short-term support on a flexible basis, though they do enter into large, long-term contracts for assistance in carrying out major program activities. Health plans, on the other hand, are bound by fewer of these limitations, but their access to discretionary funds is frequently limited, mainly because health plans rely on a monthly capitation funding stream that is both tight and poorly suited to generating excess revenue that can be used for discretionary purposes. Consumer groups have little money of their own to support interventions, and many funding sources do not counter the support of consumer groups to be a top priority. It also appears likely that federal support for technical assistance on Medicaid issues will be limited because of policies calling for the devolution of program responsibility to the states. However, to the extent that state priorities coincide with federal priorities associated with implementing the Medicare Prescription Drug Improvement and Modernization Act of 2003, some support might be forthcoming. Pharmaceutical benefits and dual eligibles would appear to be the area of greatest overlap.

B. CONCLUSIONS AND RECOMMENDATIONS

1. Accomplishments and Areas of Strength

The findings show that MMCP has been an effective program over the period covered in our evaluation (2000–2003). MMCP's increased emphasis on integrated technical assistance and other support targeted to state Medicaid agencies and Medicaid managed care plans has led many organizations to change how they think and has produced concrete changes in practices in several states and plans. To that end, MMCP has moved beyond merely providing information; it now works with organizations and their core staff to promote change. Such intensive "hands-on" involvement by well-qualified staff and consultants appears to be a critical factor in

MMCP's success. Core audiences and others with an interest in Medicaid managed care view MMCP, and CHCS generally, as a unique resource oriented toward their practical needs.

Further, while we focused on evaluating MMCP as a distinct program, it is important to credit MMCP with allowing CHCS to evolve into a organization that states, health plans, and funders look to more generally as a vital resource. MMCP played an essential role in CHCS' evolution; it made a substantial investment over the last 10 years that allowed CHCS to reach out first to states and then to health plans and other funders to build long-term relationships. Core audiences do not distinguish between MMCP and CHCS, suggesting that the organization that MMCP helped build has created synergies across diverse programs and funding sources. Such capacity is likely to be important in supporting future efforts to improve care in Medicaid as states and health plans struggle with how to respond to today's fiscal environment while enhancing the value of care provided under the program.

2. Priorities and Areas for Attention

We first identify, by core audience, what appear to be the most important functions MMCP has performed and how they might be strengthened. To speak more broadly about the future, we then discuss priorities and areas for attention across audiences.

State Medicaid Agencies. MMCP's work with states appears particularly valuable in performing three functions: (1) communicating concepts and approaches that can help "move the field," (2) orienting new directors and program leaders to the key issues they will face and to some tools for addressing them, and (3) working with individual states alone or in the follow-up of group-based activities to help them implement initiatives and program features. MMCP's ability to convene Purchasing Institutes is an important "entry point" for assistance, although one-on-one contact with key state leaders is essential in establishing relationships. CHCS'

command of an array of materials, qualified staff and consultants, Web-based services, and other resources has helped the Center earn a reputation as a "go to" place.

From our perspective, at least three challenges pose obstacles to CHCS' continued success in working with states to fulfill program goals established by RWJF. First, in a field where leaders turn over rapidly, CHCS staff need to make an effort and take time to work continually at building and maintaining relationships with major state leaders. Second, with support based on reputation, CHCS needs to maintain its reputation for qualified staff and consultants expert in the areas they address. We encourage CHCS to continue its efforts to build capacity internally as well as through contractual arrangements. With respect to states, the recent hire of an experienced former Medicaid director to join the CHCS staff is a positive sign.

Third, in a climate that seeks "instant solutions" and "magic bullets," CHCS will need to determine how best to focus its work so that innovations are both acceptable and realistic. The current environment will not support many cost-increasing strategies, yet rapidly introduced cost-saving innovations are limited. Perhaps the best way that CHCS can help states negotiate the current environment is to ensure clarity as to the meaning of "value-based purchasing" and identify where and how states are best able to influence the care delivery process.

Health Plans. The evaluation's findings indicate that MMCP's work with health plans has been particularly valuable in (1) helping plans expand the use of targeted quality improvement initiatives within their system and (2) providing a point of support to Medicaid-dominant or similar plans whose needs are not well served by traditional associations and quality improvement organizations. While MMCP's health plan–related activities leveraged intensive work (workgroups) to build knowledge more broadly (workshops, Quality Summit, and toolkits), change also varied with the intensity of activity. Plans involved with MMCP in several BCAP-related activities said that the activities changed both how they think and how they practice.

They also reported that they applied the framework developed to support BCAP across a diverse set of areas.

The main weakness to date in the BCAPs that we studied for the evaluation relates to their ability to generate relevant measures of process and outcome with which to gauge their success.[49] The BCAPs we studied here had few consistent measures across participants beyond established HEDIS measures. Moreover, the measures involved indicators that at times were difficult to interpret and often lacked consistently available plan data specific to tested interventions. Those active in commercial quality improvement activities say that such challenges are not unique to Medicaid and reflect the early learning process involved in the institutionalization of any change (Martin, personal communication, 2004). However, MMCP still may want to provide plans with more focused help in identifying relevant measures that can be developed from available plan data for translation of data specifications into concrete and useable measures. Such assistance would be consistent with the limited technical assistance support MMCP seeks to provide to BCAP participants.

The second area of improvement for the BCAPs, as related to health plans, involves developing greater clarity on how BCAP priorities are set and what outcomes each BCAP seeks to achieve. Theory supports focusing the BCAPs on areas with evidence of effective practice and associated performance measures that can form the basis for change. However, good evidence does not exist on how to care for some of the most challenging medical situations faced by subgroups of Medicaid beneficiaries; at the same time, appropriate measures may be lacking. For example, maternity is an important Medicaid service, but there is only limited knowledge of

[49] Though CHCS has added to its staff experts in this area and is said to be strengthening its resources, we saw little change reflected in BCAP 5. However, BCAP 5 was particularly challenging (diverse plans focused on building knowledge of how to handle some of the most difficult problems facing Medicaid), and staff have focused on the BCAP collaboratives such that BCAP 5 probably is not a good test of current capacity.

how to modify care systems to improve birth outcomes. In addition, interventions are not well formulated for and targeted to individuals whose multiple chronic conditions, comorbidities, or environmental circumstances may limit their ability to adhere to treatment. Similarly, effective ways of coordinating care for individuals with complex needs who may receive services from multiple programs also are limited. The BCAPs studied for the evaluation included workgroups with relatively well-developed evidence of effectiveness and ways of measuring it (BCAP 3 for asthma and BCAP 2 for prevention), a workgroup where both evidence on effectiveness and associated measures were poorly developed (BCAP 5 for adults with chronic illness and disability), and a workgroup that fell somewhere in between on this dimension (BCAP 1 for birth outcomes).

Clearly, the documentation of demonstrated improvements proved much easier in well-developed areas than in areas where clear models for interventions were limited and appropriate measures typically absent. In this context, we suggest that MMCP has two choices. The first is to focus BCAPs in areas with the strongest evidence on effectiveness, meaning a focus on either selected chronic conditions or conditions common to children and women of childbearing age. The second choice is to expand BCAP work to important but less developed areas of care, but modify BCAP goals in these cases to reflect the state of current evidence. In areas with strong evidence and measures, BCAP could focus on making documentable changes. In areas where evidence is less developed, BCAP could be viewed as an incubator for ideas and models that can be refined and shared more broadly among health plans.

Consumer Groups. As noted previously, MMCP has not devoted considerable resources to consumer groups; its main intervention has taken the form of small grants accompanied by limited technical support. While valued by its core audience, the grants led to little sustainable change. Yet, the complexity of the health care system is such that aid to consumers in navigating

the system is essential. Further, without appropriate consumer engagement, many quality improvement initiatives are doomed to fail.

At a minimum, MMCP's work with states and health plans needs to center on helping state Medicaid managed care programs/plans operate on behalf of consumers. For example, while consumers can be "educated," low levels of health literacy and barriers to communication are likely to remain relatively "fixed" challenges to success in the Medicaid program. To what extent can interventions be designed to work with rather than in tension with the population served? Are there administrative best practices, in addition to clinical best practices, with sound evidence to support improvements (e.g., enrollment and auto-assignment, registering children, best practices in communication)?

Looking toward the future, both MMCP and RWJF need to sharpen their vision of consumer-related goals. Consumers should not be listed as a core audience of MMCP unless the program intends to devote substantially more resources toward this end. Our evaluation findings clearly indicate that substantially more resources and investments are needed to create a true partnership with consumer groups and that such groups find few alternative resources that target their needs. RWJF may want to consider whether consumer education is properly the province of CHCS or another organization and whether it should be targeted specifically at Medicaid users or more generally at low-income consumers, many of whom cycle on and off various forms of coverage, thus raising additional issues. Certainly, however, MMCP can encourage consideration of consumer concerns as states and health plans work to improve their systems.

Cross-Cutting Needs and Issues. Our evaluation also provides some insight into broader issues that relate to MMCP's activities and scope. First, while we did not study the geographically focused BCAP collaboratives sponsored by others, the barriers encountered by plans in coordinating their systems with states point to the possible value of collectively

engaging all stakeholders in quality improvement. One caveat is in order, however: competing stakeholders may be unwilling to share data, especially given that tensions are sometimes high in a given market. Activities that include both national and local collaboratives may best help target support to stakeholders in diverse markets and states. Similarly, CMS staff could be invited to participate in some activities but not in others. For example, regional office staff could be invited to participate in geographically focused collaboratives that include state and plans in their regions.

Second, as in our original short-term assessment of MMCP, we encourage CHCS to think carefully about how to balance its flexibility with sufficient long-term commitment and focus to generate the types of long-term improvements in capacity that it seeks. While substantially more focused than earlier, CHCS continues to have broad ambitions for MMCP. The tendency to respond to current interests may be inevitable for a grant-funded center, but taking on additional activities within a fixed budget calls for trade-offs between the resources available for maintaining current work with states and plans and strengthening content and follow-up associated with Purchasing Institutes, BCAPs, and other activities. RWJF interests will affect the breadth of CHCS' focus and the signals CHCS sends.

Third, while RWJF asked us to evaluate MMCP, the evaluation findings clearly show that MMCP does not exist as a discrete program in either the minds of CHCS staff or the perceptions of the core audiences. As RWJF and CHCS discuss how best to leverage current work, they would be well advised to develop a better shared understanding of what RWJF is buying with its support of MMCP, as discussed below.

C. RECOMMENDATIONS TO RWJF

We believe that the evaluation findings provide solid evidence of success for MMCP as it operated over the period of the evaluation (roughly 2000–2003). With RWJF's support, CHCS

staff have become a respected resource for states, health plans, and some others who appreciate the Center's role as a source of practical advice on operational insights into Medicaid managed care. Further, evidence suggests that the program has generated not only support but also concrete change implemented by states and health plans. The integration of grant support into an overall program of work with states and plans to assist them in making change appears to be an effective intervention strategy.

The evaluation has some obvious constraints. First, MMCP is an evolving program such that we can evaluate past performance only, not the influence of emerging initiatives. Still, the evaluation provides strong support that MMCP has enabled CHCS to become a well-regarded resource. Moreover, the investment in relationships and vehicles for assistance will support future activities. Second, MMCP's focus is broad, with no formal benchmarks for assessing accomplishments against expectations. We have tried to specify the types of changes MMCP has produced and how stakeholders view the program so that RWJF staff can judge MMCP's value for themselves. Third, while focused on MMCP, our evaluation was complicated by the fact that users failed to distinguish MMCP from the broader organization that MMCP's resources have helped to develop. We do not believe that this complication constitutes a major limitation in that we focused on MMCP-funded activities, and MMCP was the primary funder of the activities during the study period. However, MMCP provided the resources to build the infrastructure that allowed CHCS to evolve to its current state. Thus, the question of whether or how to distinguish CHCS and MMCP is likely to be substantially more relevant in the future.

Both our analysis and that of Martin and Kenneson also suggest that, without RWJF funding, MMCP's ability to continue its work would likely be limited. MMCP is a resource-intensive program whose success requires extensive and continuing work with states and health plans if it is to generate improvements in Medicaid managed care. While users consider MMCP

to be important and may be willing to contribute to the cost of activities, states and health plans face both fiscal and administrative barriers to supporting the types of activities supported by MMCP. At best, user support could cover only a portion of the costs. At worst, it could limit the reach of the program and its ability to serve the needs of many in the target audience, or it could even create conflicts of interest. While the federal government has an interest in the program, the current administration sees Medicaid as a state responsibility and has therefore limited the amount of federal funds available for technical assistance. Support from other foundations may be feasible. At present, however, RWJF has funded the investment in basic infrastructure that supports joint funding. While we cannot speak to the issue of MMCP's relative priority vis-a-vis RWJF's other funding demands, MMCP currently benefits from the foundation's substantial historical investment, which would be lost or weakened if RWJF eliminated future funding. Further, all indicators suggest that Medicaid will remain a critical focus for states in the years ahead and that states will look to managed care, in a variety of forms, as they attempt to enhance the value of their purchases amid a climate of increasingly tight resources.

If RWJF decides to renew MMCP, we suggest that the Center and foundation enter into a serious conversation about RWJF's expectations, both for MMCP in particular and for how MMCP fits generally within the broader context of the Center. A business plan, developed by the Center, could serve as a point of departure for the discussion, allowing CHCS to articulate where it views RWJF (and MMCP) support as essential and how it views other funding sources within the context of the overall organization.

D. RELEVANCE TO BROADER RWJF PROGRAMMING

MMCP is one of an emerging new set of programs that departs from the traditional grant model to support organizations and people who, in turn, work with core audiences to implement targeted change. In the case of MMCP, the payoff appears to be positive, though not necessarily

immediate. The changes documented here coalesced after a long period in which CHCS found "its legs" and built relationships with states, then with health plans, and then with others in the field. The program benefited from the fact that its founder was an experienced and savvy former RWJF staffer who "knew the ropes" and worked hard to shape the organization to match the changes in the environment. That individual hired staff and consultants with the skills needed to make the model work. MMCP also had strong support within the foundation from senior program staff who shared the program's vision, advocated for the required support and approvals, and tackled the issues associated with building and maintaining a strong center and organization. Such conditions do not always exist and may be hard to replicate with reduced foundation funding.

Our evaluation suggests that, if RWJF decides to pursue models similar to MMCP, it will have to confront some issues. First, if new programs are developed in organizations without an existing infrastructure to support their activities, RWJF should expect that substantial resources and time will be required to build such infrastructure. But RWJF will gain more control over the final "image" of the organization, its goals, and its activities than if it carried out the same activities in an existing organization with an established identity. Second, endeavors along the lines of MMCP require organizations and staff that are skilled in securing and retaining the support of their core audiences. MMCP's wisdom in involving former Medicaid and health plan staff as core members of the program enhanced the credibility of the support provided by the program, such that users sensed that "they speak our language." The National Review Committee (renamed the National Advisory Committee) also contributed to program credibility through "names" known to core audiences, including researchers experienced in working with state staff. Third, programs such as MMCP require a long-term investment and therefore are most productive when issues have "traction." Despite a managed care backlash elsewhere,

managed care has remained a strong albeit evolving feature of the Medicaid program in most states, allowing organizational maturation and learning. But managed care has evolved more slowly for SSI than originally projected, limiting the program contributions in this area.

In considering MMCP's renewal, RWJF staff will likely need to understand how the program fits into other quality work. One example is the work initiated by the Institute for Healthcare Improvement (IHI) and Improving Chronic Illness Care (ICIC), both of which receive foundation support. We believe that the evaluation findings indicate a complementary focus between MMCP and these programs. MMCP uses the same types of tools employed by these other programs but with a focus on how their use by state Medicaid purchasers and health plans—rather than by provider systems or provider-oriented organizations focused on "mainstream" populations and care. While the needs of the Medicaid population substantially overlap those of other populations that also may have low incomes or limited education, Medicaid also operates under a unique set of program requirements and its provider systems are fairly distinct from those in commercial practice.[50] Unfortunately, despite efforts at mainstreaming, such distinctions are likely to persist, creating ready audiences for MMCP whose needs are not well met elsewhere. MMCP can help assure that those who serve Medicaid populations are best able to take advantage of evolving experience with quality improvement elsewhere. MMCP and CHCS more generally appear to be performing a similar role in support of the foundation's work on racial and ethnic disparities in quality of care.

[50] This is so because of geography and payment, and because Medicaid includes population subgroups that many providers would prefer not to serve because they create demands that the system is not adequately structured to meet.

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DESCRIPTION OF CONTRIBUTING REPORTS

These reports were prepared to contribute to the overall evaluation by providing additional detail in specific areas addressed by MPR's evaluation of CHCS' Medicaid Managed Care Program.

PROGRAM SUMMARY

"The Medicaid Managed Care Program of the Center for Health Care Strategies: Program Summary," by Justin White and Marsha Gold

- This provides a detailed review of MMCP's history and evolution, including specific features of specific activities and the rationales for their development.

STATE SURVEY REPORT AND COMPANION ANALYSES

"Evaluation of CHCS' Medicaid Managed Care Program: Results from Surveys of State Medicaid Directors and Senior Program Staff," by Debra Draper and Marsha Gold

- Based on two surveys: (1) semi-structured telephone interviews with all state Medicaid directors between June and September 2003, with 43 of the 49 states with Medicaid managed care responding (88 percent); and (2) mail surveys with telephone follow-up to senior Medicaid managed care program staff in each state, with 160 staff from 45 states responding (94 percent response rate).
- Findings cover the awareness of CHCS and specific activities, how each is viewed, participants' perceptions of activities, the overall assessment of CHCS and its work with states, including its uniqueness, strengths and weaknesses, what states view as the major barriers to improving Medicaid managed care programs, and overall perceptions of the program and views for improvements.

This report also includes two companion analyses, which have been added as appendices:

"Evaluation of CHCS' Medicaid Managed Care Program: Results from A Survey of New State Medicaid Directors," by Julie Howell and Justin White

- Because turnover of state Medicaid directors was extensive when the original survey of states was done to support the evaluation, we conducted follow-up interviews in summer 2004 with new directors who were not included in the 2003 survey. These interviews focused on awareness of CHCS (including reaction to any CHCS efforts to involve them), reactions to the most recent Purchasing Institute (if they or their states

were involved), how directors now view the environment in which these programs operate, and thoughts on how turnover in leadership of state Medicaid programs might best be addressed for programs like this in the future.

"Analysis of Extent of Change in State Programs Based on 2003 Interviews with State Medicaid Directors," by Tara Krissik and Melanie Au

- This memo draws together findings from existing reports (from the state survey and from the review of grants) and supplements these findings with a limited amount of additional interviewing to identify outcomes from CHCS' work with states. The focus is on states that from the survey or other information seemed to have accomplished the most.

HEALTH PLAN SURVEY REPORT

"Evaluation of CHCS' Medicaid Managed Care Program: Results from a Survey of Health Plans," by Erin Fries Taylor and Marsha Gold

- Based on a mail survey with telephone follow-up to all Medicaid managed care plans nationwide. 192 plans responded for an 86 percent response rate. 63 percent were Medicaid dominant (had 75 percent or more of its enrollment from Medicaid/SCHIP) and 37 percent were commercial.
- Findings cover plan awareness of CHCS and specific activities, how each is viewed, participants' perceptions of activities, the overall assessment of CHCS and its work with health plans, including its uniqueness, strengths and weaknesses, what plans view as the major barriers to improving quality in Medicaid managed care programs, and overall perceptions of the program and views for improvement.

BCAP CASE STUDIES REPORT

"Evaluation of CHCS' Medicaid Managed Care Program: Case Studies of the Best Clinical and Administrative Practices (BCAP) Program," by Jessica Mittler, Tara Krissik, Marsha Gold, Jennifer Humensky, and Melanie Au

- This series of reports is based on a review of documents and interviews with staff from each of the health plans participating in BCAP workgroups sometime after the workgroups ended. After an introductory review of the initiative, the first three case studies focus respectively on BCAPs dealing with: (1) improving birth outcomes (BCAP 1), (2) improving preventive care for children (BCAP 2), and (3) achieving better care for asthma (BCAP 3). At the request of CHCS/RWJF, we added another analysis focused on BCAP 5, improving care for adults with chronic illness and disability. The cases then were analyzed together to comment on the BCAP strategy.

- Individual cases for each BCAP include information on the number and characteristics of plans participating in the BCAP, what they accomplished as a result of their participation, the impact of the changes on outcomes of care (including any measures of performance available), whether activity had been sustained after the workgroup ended, and other perceived benefits of participation on the plan and the care delivered.

NATIONAL AUDIENCE SURVEY REPORT

"Evaluation of CHCS' Medicaid Managed Care Program: Results from a National Audience Survey," by Tara Krissik and Marsha Gold

- Based on a brief mail survey with telephone follow-up to the third core audience of MMCP (consumer groups) and other national stakeholder groups involved in Medicaid managed care (CMS staff in central office and each region, Medicaid analysts focused on national Medicaid managed care policy from a general or state specific perspective, and Medicaid managed care researchers). 94 individuals responded, for a total response rate of 95 percent.
- Findings cover awareness of CHCS and its specific activities, CHCS as a source of information versus other sources, perceptions of the main barriers to Medicaid managed care, and overall views of CHCS and areas for improvement.

CONSUMER ACTION GRANTS REPORT

"Evaluation of CHCS' Medicaid Managed Care Program: Evaluation of CHCS' Consumer Action Seed Grants," by Megan McHugh

- Based on document review and semi-structured interviews with each grantee that received a Consumer Action grant (excluding those also serving as local Covering Kids grantees). Eighteen of the 19 grantees agreed to be interviewed. Includes data from the national audience survey that captured views on Consumer Action grants among national and regional consumer groups. (17 of the 20 consumer organizations targeted for the survey completed it.)
- Findings cover the organizations that received Consumer Action grants, the activities that were funded and the extent to which each was implemented, the results of the grants, the factors that grantees viewed as contributing to them and how sustainable were the activities. Findings also include overall perceptions of the program and suggestions for improvements.

GRANTS REPORT

"Evaluation of CHCS' Medicaid Managed Care Program: Results from the Grants Analysis," by Erin Fries Taylor and Marsha Gold

- Based on document review and semi-structured interviews with staff from a stratified random sample of grants awarded between 2000 and mid 2003 for projects at or near the completion of their grant period. All eligible model demonstration grantees (the largest grants) were interviewed. Grantees receiving smaller best practices/policy studies were selected with stratification to include representation by diverse types of organizations (health plans, consumer groups, research organizations, providers, state agencies). A sample of community integration grantees also were interviewed. 30 organizations were selected for study and 97 percent participated.
- Findings provide a description of grantmaking through MMCP and analyze the grant activities and outcomes by type of grant, the factors that contributed to those outcomes, the sustainability and replicability of activities and grantee perceptions. These include perceptions about grantmaking, the role of CHCS technical assistance, and an overall assessment of CHCS and areas for improvement.