

Contract No.: 046351
MPR Reference No.: 8973-100

MATHEMATICA
Policy Research, Inc.

**The Medicaid Managed
Care Program of the
Center for Health Care
Strategies: Program
Summary**

Contributing Report

December 2004

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ACKNOWLEDGEMENTS

This report would not have been possible without the hard work of Jessica Mittler and January Angeles, who helped write earlier iterations. Their research was indispensable and a starting point for all material included in this report. Many thanks to Beth Stevens for reviewing earlier drafts of this summary with a careful eye and for considerably raising the overall quality of the final product. Also, the rest of the evaluation staff, notably Debra Draper, Erin Taylor, Tara Krissik and Megan McHugh, contributed greatly to this undertaking and deserve much credit for pulling together relevant facts and ensuring the overall accuracy and consistency of the report. Finally, the staff at CHCS kept us abreast of their latest developments and were always willing to fill the gaps in our story.

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EXECUTIVE SUMMARY

In 1995, the Robert Wood Johnson Foundation (RWJF) established a national program focused on Medicaid managed care, called the Medicaid Managed Care Program (MMCP). The program responded to the foundation's long standing interest in care for vulnerable populations and sought to take advantage of Medicaid's movement to managed care as a way to develop improvements in the way care has been delivered to this target population. The Center for Health Care Strategies (CHCS), headed by former RWJF senior staffer Stephen A. Somers, was the new entity created to implement this national program charged with promoting the delivery of high-quality health services for low-income persons and persons with special health care needs. In 2002, Mathematica Policy Research (MPR), Inc. was commissioned by RWJF to evaluate the MMCP and inform upcoming decisions by RWJF about renewing program authority. This summary, which is being completed to support the evaluation, provides an overview of the development and recent status of activities under the MMCP. The summary is descriptive with the goal of complementing and providing the context for the evaluation findings.

HISTORICAL EVOLUTION OF THE MEDICAID MANAGED CARE PROGRAM

In the beginning, CHCS and MMCP were essentially one and the same.¹ CHCS was mainly a grant-making organization, providing grants as a vehicle for supporting innovation and identifying and disseminating best practices in publicly financed managed care. Under the MMCP, CHCS funded two types of grants: larger model demonstration grants and smaller "best practices" grants. Starting in 1997, CHCS worked to build stakeholders' capacity to undertake model demonstrations by awarding planning grants as an intermediate step. As time progressed CHCS became concerned that a programmatic strategy built entirely on grant making would not address program goals. From their perspective, grant giving on its own was reactive rather than proactive and lacked the technical assistance and support needed to work with those involved in Medicaid managed care to best achieve its goals of improving care for low income and highly vulnerable people served by Medicaid.

In 1999, CHCS responded to this concern by restructuring its activities to move beyond an exclusive focus on grant giving. The MMCP was restructured around four organizing principles: (1) informed purchasing, (2) managed care best practices, (3) consumer action, and (4) integrated systems of care. Center staff identified three core audiences for its work: purchasers of publicly financed managed care, managed care organizations, and consumer and family-based organizations. CHCS developed several core initiatives around these stakeholder groups to promote prudent purchasing and quality improvement, namely the Purchasing Institute, the Best Clinical and Administrative Practice (BCAP) initiative, and the Consumer Action Agenda.

¹CHCS funding has become more diversified, particularly in more recent years. The evaluation was originally to target the MMCP but has become more complicated as CHCS has evolved to a larger set of activities that extend beyond the MMCP but often share many of the same goals, tools, and knowledge.

- The Purchasing Institute aims to help Medicaid staff improve their purchasing skills of health services through two- to three-day seminars with continued work over the course of a year to offer targeted problem solving and technical assistance. CHCS has convened four Purchasing Institutes funded by the MMCP to date.²
- The BCAP initiative tries to enhance the ability of Medicaid health plans to provide quality care within budgetary limits by convening a group of leaders from health plans across the country to develop and replicate best practices models in Medicaid managed care. CHCS has convened five workgroups to date.³
- 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 consumer and family-based organizations. In 2001 and 2002, CHCS solicited and awarded two rounds of consumer action grants that have been distributed to 29 organizations.⁴

In addition, CHCS convened 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. CHCS also began to redesign its Web site and pay more attention to the structure of the way in which it commissioned and released reports funded through grants of diverse types.

MPR'S INITIAL SHORT-TERM ASSESSMENT

At the request of RWJF, MPR conducted a short-term assessment of the MMCP to inform decisions being made in spring 2001 about program renewal. The assessment's core was a series of case studies designed to provide early user feedback on examples of the new technical assistance strategy based on document review and interviews. Specifically, the case studies looked at the Purchasing Institute, the Managed Care Pricing Forum, the first BCAP workgroup,

² CHCS has held two other purchasing institutes funded by sources other than the MMCP: one sponsored by the Annie E. Casey Foundation in 2001 and the other sponsored by the Technical Assistance Collaborative in 2003 as part of the Resources for Recovery, a national grant program of RWJF. The California HealthCare Foundation also supported the Purchasing Institute by paying for California Medicaid staff to attend in 2000 and funding a portion of the Institute in 2001.

³ CHCS currently is holding four BCAPs funded by sources other than the MMCP, one funded by the Commonwealth Fund, one funded by the Annie E. Casey Foundation, one jointly funded by RWJF (using non-MMCP funds) and the Commonwealth Foundation, and one funded by Children's Futures and HealthWorks Consulting.

⁴ Grants in the first round were up to \$25,000, and grants in the second round were up to \$50,000. The Covering Kids and Family Access Initiative grew directly out of the first round of consumer action grants. The initiative, funded through a mix of MMCP and non-MMCP RWJF funds, gives grants up to \$125,000 to small consumer organizations, partnered with state grants and deeper technical assistance. This design reflects CHCS recognition that small grants alone are not sufficient for consumer-based interventions.

planning for the consumer action agenda and CHCS' publications and dissemination work. The case studies showed that participants viewed CHCS' initiatives as providing an important and unique product not otherwise available with positive user feedback on both the first Purchasing Institute and the first BCAP work. Support was particularly strong among states with which CHCS had worked the longest. The assessment concluded that initial indications were positive though it was still too soon to say whether the program would ultimately change Medicaid managed care. The authors expressed concern, however, that components of work were evolving independently, some on a seemingly ad hoc basis. They recommended that CHCS develop a more integrated vision of how the different components of CHCS' strategies related to one another and identify areas with critical synergies that could work together to enhance impact, including better specifying the relationship between grants and technical assistance.

CHCS believes it responded to MPR's advice as it proceeded with its ongoing strategic planning activities. CHCS folded its fourth organizing principal (integrated systems of care) into the first three because they perceived that integration was relevant to all three and the change led to a better alignment of organizing principles with particular stakeholder audiences. The principles matched their core audiences as follows: informed purchasing was paired with state Medicaid staff, managed care best practices with Medicaid health plans, and consumer action with consumer and advocacy organizations. With the elimination of the fourth organizing principle, CHCS restructured its operations so that the same staff worked on all efforts related to the audience targeted by each of the three organizing principles (e.g. informed purchasing focused on states and included institutes, grants, publications and other related activity in that area).⁵ The intent was to use this structure to better capture the synergies among activities. CHCS also decided to focus its activity around the goal of improving care and quality, rather than more broadly on purchasing. As a result, work in areas like rate setting received much less attention.

However, while CHCS became more focused, it continues to believe that its success depends on being "nimble" and programmatically flexible to take advantage of emerging opportunities and the changing landscape of state Medicaid managed care. Balancing programmatic flexibility with ongoing commitment is an issue that is fundamental to CHCS. So too is the tension CHCS faces on how best to set priorities substantively in its work on Medicaid managed care. As noted previously, CHCS was established with a focus on developing integrated systems of care for subgroups of Medicaid beneficiaries with highly complex needs (the initial focus of grant work). It still pursues this goal but has broadened its work to include a focus on overall improvements in care, including incentives for quality in state purchasing and condition-specific quality improvement initiatives. How best to balance work across areas remains an issue.

⁵ To support this goal, the Center developed five specific quality aims (e.g. improving access to a usual source of care). However the initial intent to use these as ways of measuring broader change under Medicaid managed care was dropped eventually in favor of more targeted measures of change by those participating in its programs.

RECENT PROGRAM EVOLUTION

CHCS has received \$62 million for the MMCP from its inception in 1995 through 2004. RWJF last renewed the MMCP in July 2002 and authorized \$30 million in funding over a three-year period though only \$10 million reflected new funding. The rest of the funds were consolidated from unspent funds available from previous MMCP grants. (Subsequently the MMCP received a no-cost extension for an additional two years so that renewal—originally anticipated for June 2005—would instead be considered in June 2007.) As CHCS develops during this period, it continues to search for ways to meet its goals and work directly with its key audiences. CHCS has continued to shift its focus away from grant making towards training and technical assistance activities as the best vehicles to elicit sustainable change in Medicaid managed care and bring real quality improvement to its key stakeholders.

As CHCS has completed this strategic shift, it has continued to rely on its signature products—the Purchasing Institute and BCAP initiative—to reach state purchasers and health plans; however, CHCS has built off of this framework to introduce new activities that often bring together a diverse cast of key stakeholder groups. For instance, the BCAP Quality Forum and BCAP Asthma Collaborative are derivatives of the basic BCAP approach that convene a broader group of organizations. Similarly, CHCS has used its experience with the Purchasing Institute as a base for other activities, most notably its Technical Assistance Series, which offers group technical assistance to states on a variety of state purchasing issues. CHCS also has refined existing activities. In 2003, CHCS developed a four-pronged measurement process that will be applied to future BCAPs and retrospectively to BCAPs 4 to 6, and it is developing a similar four-dimensional evaluation for Purchasing Institutes.

LOOKING TOWARD THE FUTURE

At the 1999 renewal, grant making accounted for more than half of the MMCP's resources, but since then the function has diminished in proportion to the overall budget. In addition, since the program's outset, grant making has undergone significant changes. In all, CHCS has issued six calls for proposals for various MMCP grants. Starting in 1999, CHCS linked grant making and technical assistance work more closely, and it moved toward more targeted grant making. In June 2003, the grant process became more restrictive; grant making now is seen less as a central function of CHCS and more as a training and technical assistance component. In the future, CHCS will fund no more than four to five unsolicited ad hoc grants per year. Instead, CHCS will pursue targeted solicitations, such as its latest solicitation, the Business Case for Quality in Medicaid (BCQ).⁶

CHCS has built on its core initiatives to diversify its funding and activities around areas it views as critical to delivery of care for low-income individuals and individuals with special needs. Thus, it is important to distinguish between CHCS and the MMCP; CHCS is no longer funded solely through the MMCP. Yet, as CHCS adds additional activities and funding sources,

⁶ The Business Case for Quality initiative seeks to demonstrate and evaluate the ability of Medicaid stakeholders to invest in quality improvement activities. CHCS views the BCQ as hugely important to its mission. The Business Case for Quality is jointly funded by the Commonwealth Fund and the MMCP.

the MMCP also is not a totally distinct program that can be judged separately from its context, because the MMCP has provided the base for many activities funded elsewhere and provided CHCS with a level of “core” funding that has given it flexibility to diversify. Our evaluation of the MMCP focuses on that program, but the findings will need to take into account the context in which that program now operates.

In the future, CHCS hopes to continue on its current path, working directly with its key stakeholder groups, promoting collaboration among these constituencies, providing training and technical assistance activities, refining its measurement strategy, issuing targeted grant solicitations, and diversifying its funding streams; however, CHCS also has plans to expand its reach beyond its current niche. First, CHCS hopes to continue its traditional core activities while setting its agenda, or “squawking,” more at the national level with the goal of communicating better the Medicaid managed care environment and the operational needs and opportunities it may present for policymakers. Second, CHCS sees an opportunity to leverage its work on Medicaid with other sectors—Medicare, commercial, the uninsured—as its ultimate long-term goal, and hopes to capitalize on its Medicaid work to inspire broader quality improvement. Third, CHCS wants to incorporate health care providers into CHCS activities through partnerships with national organizations that focus on quality improvement efforts.

Finally, CHCS and its board envision a dynamic organization that evolves as it learns and as environmental circumstances change. Though such evolution creates more challenges for evaluation than a static program form, Center leadership believes that dynamism is a core part of CHCS’ focus and approach to the MMCP. While such transitions create challenges for any evaluation, MPR’s work still needs to look backwards as well as forwards. That is, though CHCS’ strategy for the MMCP continues to evolve, the program’s goal—improving care for those in Medicaid managed care—remains central and static. RWJF seeks to learn from the MPR evaluation CHCS’ success and track record historically in delivering on that goal and what MMCP experience implies for the relevance to RWJF of future work in this area.

I. INTRODUCTION

This summary provides an overview of the rationale, development, and current status of activities under the Center for Health Care Strategies' (CHCS) Medicaid Managed Care Program (MMCP). Since its outset, CHCS has been charged with improving the quality of health and health services for low-income persons and persons with special health care needs. CHCS has planned, designed, and implemented a number of activities sponsored through the MMCP that promote quality improvement in Medicaid managed care. This summary provides a detailed description of the design and development of these activities. It is meant to provide context and descriptive information that can complement the evaluative products we are producing.

This synthesis is being completed to support an evaluation conducted by Mathematica Policy Research (MPR), Inc. that builds on a short-term assessment of the MMCP that MPR completed in 2001. This longer evaluation, funded by the Robert Wood Johnson Foundation (RWJF) in 2002, aims to provide detailed, systematic feedback on what the work of CHCS on Medicaid managed care has accomplished to inform RWJF's upcoming decisions about renewing program authority. The present summary, which expands upon the program summary developed for the earlier assessment and updates an interim program summary completed in March 2003, focuses on developments since the short-term assessment in 2001 and is based on a review of internal RWJF and Center documents as well as interviews with key parties in both organizations.

CHCS was formed around the MMCP, but over time CHCS has built on this core program to diversify its funding and activities around areas critical to delivery of care for low-income populations in public programs. Thus, it is important to distinguish between CHCS and the MMCP. Our evaluation of the MMCP focuses on that program, but the findings need to take into account the context in which that program now operates. Thus, we include relevant information throughout the synthesis on activities that are not funded through the MMCP that either relate directly to a specific MMCP initiative or connect integrally to the strategic development of CHCS.

We begin by describing the impetus for creating CHCS, its early history, and its strategic development (Chapter 2). We then review the MMCP's specific activities around its key stakeholder groups and how they relate to this strategic development (Chapter 3). Next we look at specific MMCP initiatives that cut across multiple stakeholder groups and important miscellaneous activities (Chapter 4). Finally, we conclude with a short summary of the development of CHCS since its creation and what this means for the MMCP (Chapter 5).

II. OVERVIEW OF THE IMPETUS FOR CHCS AND ITS HISTORY AND STRATEGIC DEVELOPMENT

In the beginning, the Center for Health Care Strategies was mainly a grant-making organization that provided grants to support innovation and identify best practices in publicly financed managed care. Over time, CHCS' focus shifted away from grant making and toward technical assistance and several core initiatives directed at its main audiences. CHCS sees training and technical assistance as the best vehicles to elicit sustainable change in Medicaid managed care and bring real quality improvement to Medicaid beneficiaries. More recently, CHCS has continued to add to its menu of activities and searched for ways to work directly with its key stakeholders.

A. IMPETUS FOR AND EARLY HISTORY OF THE MMCP, 1995-2001

The impetus for creating the Center for Health Care Strategies stemmed from the emergence of broad-based Medicaid managed care initiatives among states in the mid-1990s as they sought to control health care costs while responding to pressures for expanded coverage (Gold 2000). Both the Robert Wood Johnson Foundation and the broader health policy community expressed considerable concern over the capacity of states to mount far-reaching change over a short period, particularly in developing managed care models that would be appropriate for those individuals with special medical or social needs.

In January 1995, RWJF's board of trustees authorized \$5 million to establish a national program office focused on Medicaid managed care; six months later, the board approved an additional \$15.9 million in funding over five years. In the early years, CHCS focused on grant making in areas defined by the authorization, including \$10 million in larger grants for model development and \$4 million in grants of up to \$100,000 for feasibility studies, technical assistance, and policy grants. In an internal assessment of the MMCP in late 1998, RWJF staff identified the following as CHCS' two most notable contributions: (1) a series of products that have been helpful both to practitioners and observers of Medicaid managed care and (2) the role of CHCS as a neutral convener with the capacity to bring together diverse stakeholders to discuss difficult issues facing the field.

RWJF's assessment, however, also observed that the field of Medicaid managed care had progressed less rapidly than expected and noted that CHCS' impact would be strengthened by undertaking improvements in defining, communicating, and executing its strategy. Based on this feedback and CHCS' internal strategic planning process, CHCS intensified its technical assistance activity and began to solicit grants on a more targeted basis. To guide the next five years of operation, CHCS reformulated its objectives for the MMCP in more strategic terms, specifically by developing initiatives targeted to work more directly with key constituencies (i.e., state Medicaid agencies and managed care organizations) on high-priority needs related to quality improvement.

In October 1999, RWJF's board of trustees renewed the MMCP's authorization for an additional five years. The \$25 million authorization included an expanded technical assistance and training component that focused on purchasers, health plans, and consumers in 2004. While

\$13 million of the \$25 million was allocated to model development through planning and demonstration grants, almost half (\$12 million) of the sum was earmarked for new technical assistance and training activities to build capacity. Of the \$12 million, \$5 million was allocated for small grants to supporting studies useful to practitioners and \$7 million to taking advantage of CHCS' convening role by targeting special initiatives. These included:

- A Medicaid purchasing institute developed as the State Medicaid/State Children's Health Insurance Program (SCHIP) Purchasing Institute or SMCPI (\$2 million)
- A Medicaid break-through series on best practices that has become the Best Clinical and Administrative Practices initiative or BCAP (\$3 million)
- A rate-setting forum called the Managed Care Pricing Forum (\$1 million)
- A Consumer Action Agenda to increase consumer involvement and institutionalize consumers' role in managed care program decisions (\$0.5 million)
- A stakeholder project working with the Health Care Financing Administration (HCFA) and others to gain consensus on special needs populations (\$0.5 million)

All but the stakeholder project remain in place today, though the focus of the projects has been refined and intervention strategies sometimes modified.⁷ For example, the Managed Care Pricing Forum altered its scope to cover broader operational issues in managed care and was renamed the Managed Care Solutions Forum.

As these initiatives were being implemented, CHCS continued the strategic planning process initiated in response to RWJF's 1998 internal assessment. Based on the results of the process, CHCS created four organizing principles for its programs and activities:

- ***Informed Purchasing.*** The goal was to promote the purchasing of high-quality and cost-effective managed care services by state Medicaid programs, because states lacked the time and resources to build infrastructure for value-based purchasing. The major strategies included the Purchasing Institute, the Pricing Forum, grant making, and technical assistance.
- ***Managed Care Best Practices.*** The goal was quality improvements in clinical and administrative practices in managed care, because health plans lacked sufficient opportunities to come together on their own and consider best practices. The major strategies to promote best practices included the BCAP initiative, grant making, and technical assistance.

⁷ The stakeholders' project was over by 2000. Staff perceived that the project's success was limited by the difficulty in moving from process to substantive consensus among so diverse a set of stakeholders. The Center shifted resources from the stakeholders' project and additional funds were allocated to the BCAP program, giving it a \$3.8 million budget over five years.

- ***Consumer Action.*** The goal was to promote the ability of consumers to navigate health care delivery systems and institutionalize a consumer role in the design, implementation, and monitoring of publicly financed managed care. Consumers often were the forgotten constituency with little involvement or formal role in the implementation or operation of Medicaid managed care
- ***Integrated Systems of Care.*** The goal was to promote the integration of services and funding across public agencies, managed care organizations, and providers, because collaboration and synergies across stakeholder groups were viewed as necessary preconditions for improving quality in the delivery of health care. The major strategies were grant making, and technical assistance.

Today, only the first three of the four organizing principles remain in force. “Integrated Systems of Care” was incorporated into the other three organizing principles, because it was not viewed as a distinct objective. This also allowed CHCS to better align its goals with its work with each of what it viewed as its three key constituents: states, Medicaid health plans, and consumers. This selection reflects what CHCS viewed as an important distinguishing feature for the organization—its ability to serve as “neutral ground” for bringing together all affected constituencies (not just the states). Through its strategic planning process, CHCS defined its core audiences as follows:

- ***Purchasers of Publicly Financed Health Care.*** For the MMCP, “purchasers” were primarily Medicaid directors and staff and SCHIP program staff. The latter was focused mainly on SCHIP programs operated through Medicaid because the issues faced by Medicaid-based SCHIP programs are similar to those of Medicaid, unlike “standalone” programs whose models often rely on private sector insurance models. (The SCHIP focus has become less identifiable over time, perhaps because the programmatic issues related to care delivery are not distinct from Medicaid in Medicaid based models). In addition to grants, the main vehicles for forming relationships with the above individuals were the Purchasing Institute, the Forum, and small-group consultations. Over time, CHCS came to view its audience as not just states seeking to lead the Medicaid managed care field but also other states that face similar issues and that may be ready to take steps to address them, though they may not be in a position to develop more complex solutions as the first group.
- ***Managed Care Organizations.*** For the MMCP, these are managed care organizations or health plans that participate in public programs—primarily Medicaid and SCHIP. Whereas RWJF has a long history with states, it is less well known to health plans and also less experienced in pursuing grants. Historically, therefore, CHCS viewed working with Medicaid managed care plans to be a challenge. While CHCS has used grants to reach MCOs, they held out the most hope for visibility and influence with plans through CHCS’ work with BCAP and other initiatives. State primary care case management (PCCM) programs also participated in BCAP.
- ***Consumer and Family-Based Organizations.*** The MMCP renewal grant also encouraged an increased emphasis on consumer involvement, because RWJF saw consumers as an important constituency that was not represented in the Medicaid

managed care arena. It provided funds that were used to establish the Consumer Action Agenda initiative. In addition to undertaking policy studies focused on consumer issues, CHCS wanted to help consumers better navigate complex health care systems and institutionalize a consumer role in publicly financed managed care.

In 2000, CHCS received an additional one-year grant of \$2.8 million to support staff activity related to the above-mentioned initiatives. This grant, which served as the impetus for MPR's initial evaluation, was considered and approved at an April 2001 board meeting.

B. RESPONSE TO SHORT-TERM ASSESSMENT, 2001-02

1. Short-Term External Assessment

At the request of RWJF, MPR conducted a short-term assessment of CHCS' Medicaid Managed Care Program to inform spring 2001 funding decisions by the RWJF Board of Trustees (Gold and Mittler 2001). The assessment's core was a series of five case studies that traced the history and experience of five important programs operated under the MMCP. Specifically, the case studies looked at the Purchasing Institute, the Managed Care Pricing Forum, a BCAP work group, the Consumer Action Agenda, and publication and dissemination activities.

The assessment concluded that there was strong support for these initiatives from CHCS' major constituencies, with evidence most compelling for public purchasers (especially Medicaid staff) who have had the longest history with CHCS. Among all constituencies, the perception was that CHCS was providing an important and unique product not otherwise available. Particularly attractive to participants were the interactive forums and their focus on operations; the forums were topically focused, strong in content, and small in scale.

The report noted that it was too soon to determine whether the MMCP's interventions actually resulted in program change. The authors suggested that CHCS could improve its efficiency and effectiveness by developing a more integrated vision of how the different components of CHCS' strategies relate to one another and then identifying areas with critical synergies. According to the authors, areas that needed particular attention included: (1) the relationship between grants and direct hands-on work; (2) the relationship between general technical assistance and technical assistance provided through the SMCPI; and (3) the relevance of particular products to diverse audiences and priorities for translation (e.g., consumer training in rate-setting method and issues, health plan interests in coordinated care reports). The authors also recommended that CHCS solicit an external review of the current distribution of staff responsibilities to determine whether the allocation supports the concentration of time needed for specific programs and the synergies and economies needed across them as well as the in-house strategic capacity important to achieving Center goals.

2. Strategic Planning

In the period following the short-term assessment, CHCS engaged in a number of strategic planning activities that focused on increasing the synergy between various MMCP products and establishing a basis for measurement of results.

a. Focus on Synergies

In response to the evaluation, CHCS redesigned its business processes and redefined its program units in accordance with its three organizing principles. Administrative functions such as grants management and meeting planning were consolidated under the same leadership to more efficiently organize the work processes associated with executing grant making and special project activities and thereby increase the link between the MMCP's grants and technical assistance activities. For example, some participants in the Purchasing Institutes and the BCAP workgroups now also would receive grants through the MMCP. Grants would be used to either help states or plans reach a stage of readiness that would allow them to participate in the Purchasing Institute or BCAP, or to help them implement a project that was developed in one of CHCS' technical assistance activities. More recently, CHCS has continued to capitalize on synergies across stakeholder groups. Through a combination of funding from the MMCP and the Commonwealth Fund, CHCS is implementing a cross-cutting initiative on improving care for racially and ethnically diverse populations, sponsoring various activities on the topic, including a purchasing institute, a BCAP workgroup, and a Quality Summit to communicate best practices and lessons learned from the other two activities.

b. Focus on Quality Aims

In response to the 2001 evaluation, CHCS developed five quality aims to help the program measure impact:

1. Improve access to a usual source of care and appropriate specialty services
2. Increase the use of effective preventive care services
3. Prevent unnecessary hospitalizations and institutionalizations
4. Promote clinical quality by using accepted standards of care
5. Build organizational capacity to improve managed care services

As part of an effort to focus CHCS' objectives and assign priorities, as well as to move measures forward, CHCS decided that each of its activities—including grant making, technical assistance, Purchasing Institutes, and BCAPs—must relate to one or more of the quality aims. For instance, CHCS changed its grant application to require potential grantees to address one of the five quality aims.⁸ CHCS also planned to develop the systems and training activities needed to report on program outcomes for each quarter. It intended to measure performance on each of its activities, such as grant making, in order to assess the impact each activity had on the organization as a whole. Since the quality aims were established, CHCS has reconsidered this approach and instead opted to measure program impact and performance along different dimensions (described in the Standardizing Measurement and Evaluation section below). In 2001, performance measures were a fledgling, inchoate idea, but since then CHCS has given

⁸ The current grant application has the same requirement.

much consideration as to how to design them. Meanwhile, CHCS has preserved the quality aims, while de-emphasizing them as the sole focus of CHCS' quality improvement agenda. The de-emphasis on use of system-wide performance measures reflects the tensions involved in assessing impact when a program (like MMCP) is only one of a number of influences on a large, diversified and dynamic market.

C. BUILDING CONSTITUENCIES, 2003-04

As CHCS has continued to develop, it has moved away from grant making and instead searched for ways to work directly with its key audiences, including greater use of technical assistance. In 2003 and 2004, CHCS planned and began implementing several key strategic shifts, including diversifying funding, leveraging collaboration, standardizing evaluation and measurement, refining its approach to grant making, and diffusing its work. Put together, Center staff believe these strategies have helped them to re-tool and refine the infrastructure that CHCS has built around its key constituencies. This section describes each of CHCS' most recent strategic shifts and how each impacts the overall strategic development of CHCS.

1. Diversifying Funding

As environmental pressures continue to squeeze foundation budgets, CHCS has made a concerted effort to diversify its funding streams. As a result, CHCS has become less dependent on MMCP funds and increased the percentage of money that it receives from other funding sources. In fiscal year 2005, non-MMCP funds constituted 48 percent of the total non-grant budget, whereas they constituted 19 percent of the total non-grant budget in 2002 (Correspondence with Demetira Taitt, CHCS Director of Finance, on 8/20/04). Partnerships potentially offer new areas of focus for CHCS and new opportunities and ways for constituents to use CHCS.

CHCS now receives money from a number of foundations. Overall, since 2000, CHCS has received about \$9 million from non-MMCP funds, compared to \$30-35 million in MMCP funding.

Since its inception, CHCS has received over \$1 million from the California HealthCare Foundation, over \$2.2 million from the Annie E. Casey Foundation, approximately \$500,000 from the Commonwealth Fund (plus it awarded \$394,000 to the University of North Carolina for an evaluation of the Business Case for Quality), and over \$400,000 (over five years) from the Agency for Healthcare Research and Quality (AHRQ) via the Lewin Group. CHCS also received approximately \$160,000 from the Packard Foundation for the initial design and development of the BCAP Collaborative model and more recently for work on Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for children.

Center staff say they have tried to engage in partnerships that coincide with CHCS' overall strategy of moving toward training and technical assistance initiatives, rather than involving itself in partnerships that draw CHCS away from its core competencies and strategic focus. For instance, CHCS is serving as a subcontractor to the Lewin Group for the AHRQ User Liaison Series for \$436,000 to offer direct technical assistance to participants in Lewin training activities, including content expertise on purchasing issues and on rapid cycle improvement and

measurement techniques. Diversification of funding should allow CHCS to spread its influence and branding across a broader network of players in the quality improvement arena.

CHCS says it hopes to expand its reach further by collaborating with groups like the Institute for Healthcare Improvement (IHI) and the Improving Chronic Illness Care (ICIC) program. RWJF is encouraging these organizations, all of which are RWJF-funded, to find the best ways to work together. CHCS has little experience with provider-oriented quality improvement organizations like those targeted by ICIC and IHI. CHCS does not have a strong history of working with these provider-oriented groups, each of which has strong views of how to approach quality improvement. In particular, CHCS initially planned to collaborate on BCAP with IHI but couldn't reach an agreement. More recently, the Center has made strides toward collaborating with these organizations. CHCS worked with an ICIC grantee to establish a BCAP Collaborative in Indiana. CHCS also is working with the California HealthCare Foundation to jointly launch an effort that works with Medi-Cal health plans to target high-volume practice sites for improvement. CHCS, ICIC, and the National Initiative for Children's Healthcare Quality are partnering in this project. Finally, CHCS and IHI are working together on the AHRQ Disparities project, which focuses on commercial and Medicaid health plans.

2. Leveraging Collaboration

CHCS says it continues to search for opportunities to leverage collaboration and promote synergies between its three primary audiences. CHCS has introduced a number of new approaches with this aim. Center staff hope that bringing together its key audiences will allow the stakeholder groups to pool their collective knowledge and experience and to apply these resources to collaborative problem solving as a way to devise more creative and effective solutions to issues of purchasing and best practices. For example, under its two Asthma Collaboratives (funded outside of the MMCP) CHCS assembled a group of state Medicaid officials, managed care plans, providers, and consumer-focused organizations to develop and implement clinical and administrative practices to improve asthma care for Medicaid enrollees. These groups are collaborating to structure quality improvement activities, develop short-term and long-term measures, and disseminate findings. Collaboratives build on BCAP experience but differ fundamentally in their starting assumptions in that the new work assumes that success might best be achieved by bringing in diverse participants, not just a single stakeholder (e.g. health plans who were the initial focus) whose work needed to be distinct from others because of the potential conflicts that might exist across stakeholders.

CHCS' changing perspective is reflected in its most recent Quality Summit. CHCS initiated the BCAP Quality Summit to help health plans discuss quality improvement projects and think about best practices. However, CHCS opened registration to the second Quality Summit, held in March 2004, beyond health plans to a broader group of organizations. While health plans continued to represent the majority of attendees, other groups included primary care case management (PCCM) programs, state Medicaid agencies, and other quality improvement organizations. The multiple types of organizations that attended the Summit broadened the well of ideas recommended for improving quality and helped diffuse CHCS' work to a wider audience.

To obtain the funding it needs to support the work it seeks to do, CHCS also has fostered collaboration among a coalition of funders. Such coalition funding tends to be challenging

because each foundation has its own goals and often may want a unique identity for its products. CHCS held a small group consultation to discuss how to improve the efficiency, effectiveness, and quality of Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for children. Small Group Consultation: Improving the Implementation of EPSDT within a Managed Care Environment (a small project of less than \$100,000 total) brought together a coalition of funders that included the Commonwealth Fund, the Annie E. Casey Foundation, the David and Lucile Packard Foundation, and the Robert Wood Johnson Foundation (through MMCP funds). Phase one of the project lasted from August 2003 to December 2003, and phase two is scheduled to begin in 2004. The project demonstrates the potential to co-opt multiple foundations into trying to achieve a common objective.

3. Standardizing Measurement and Evaluation

In 2003, CHCS started to develop a measurement strategy to determine the success of the activities it funds through BCAP. Prior to 2003, CHCS had expressed interest in creating standardized measures that all BCAP participants would use but decided that it did not have the credibility among its constituents to do so. CHCS now believes that it has established sufficient credibility among states and health plans such that these groups are willing to provide the data needed to support analyses around the effectiveness of Center activities. CHCS has identified several reasons for devising a measurement system, including to reveal improvement opportunities, monitor interventions, determine if changes being made are improvements, prove best practices for internal and external diffusion, and show that money spent on quality improvement is worth the investment. CHCS hired Jane Deane Clark in 2003 as Senior Program Evaluations Officer, now Director of Evaluation and Analysis, to lead the measurement and evaluation efforts.

CHCS has crafted a four-step measurement process for evaluating the success of participants in its BCAP initiative: (1) pilot specific process measures, (2) common process and outcome measures, (3) normative benchmarks, and (4) measurement scales. First, participants in a CHCS activity must create pilot process measures that are collected for each individual project and are unique to each pilot activity. These are chosen by participant teams as useful to them to monitor their pilot project. Then common process and outcome measures are collected by participating teams and collected in a standard way. All participant teams in an initiative share the same common measures. Next, normative benchmarks are created—CHCS is still thinking through this step. Finally, scales are created to see how well plans are moving during the process and to help think beyond the pilot. CHCS has developed a series of three scales that measure the progress of a team, the sustainability of the effort, and the effectiveness of diffusing the project's results.

The California BCAP Asthma Collaborative, funded by the California HealthCare Foundation, was the first activity where common measures were applied across all health plans, which allowed for increased comparability. CHCS was able to monitor the progress of each team by tracking them across the same quantitative dimensions, such as asthma prevalence, asthma utilization per capita, asthma utilization per member with asthma, and appropriate use of medications as reported to the National Committee for Quality Assurance (NCQA) for the Health Plan Employer Data and Information Set (HEDIS). CHCS plans to extend the measurement process to future BCAPs. Unfortunately, CHCS introduced the changes too late to

be used in BCAPs 4 to 6 (4 and 5 being MMCP supported). Instead, Center staff say that retrospective evaluations will be conducted for plans that participated in these BCAPs.

CHCS also has begun work on developing evaluations for its other initiatives. For example, attendees of future Purchasing Institutes will be evaluated on a four-dimensional “maturation/sophistication” scale across the following categories: (1) leadership, (2) infrastructure, (3) marketplace, and (4) quality capacity. CHCS likely would collect measurements across these dimensions for each participant at the Institute and collect them again some time after the Institute to assess whether states have matured and become more sophisticated in the way it approaches purchasing. This scale is still in the formative stage. One complicating factor for evaluating Purchasing Institutes is that states have repeated interactions with CHCS, and Center staff are struggling to determine how to isolate the individual effects of one interaction. The issue makes it difficult to establish causality for quality improvement activities. CHCS also plans to evaluate the success of grantees on a scale from 1-5. Grants ranked as a 4 or 5 were provided as feedback to the National Advisory Committee during a meeting in summer 2004.

4. Refining Grant Making

CHCS now views grant making more as a training and technical assistance component, rather than a central function of CHCS. This admission is in sharp contrast to how CHCS operated at the inception of the MMCP, when the program revolved around traditional grant making. Since then, CHCS has recast its core functions toward its direct work with stakeholders and away from its grant making apparatus. Starting in 2003, only a handful of ad hoc grants are available to applicants. These grants and future ones that are awarded will be less than \$100,000. By offering more targeted and smaller grants, CHCS hopes to reach a wider audience using less money and to fund only those projects that advance CHCS’ agenda.

CHCS’ most recent grant offering, named the Business Case for Quality, embodies the new approach. CHCS’ director, Stephen Somers, took issue with a recent *Health Affairs* article, entitled “The Business Case for Quality,” (Vol. 22, Number 2), because it failed to mention Medicaid managed care as a viable method to save money through investments in quality improvement for chronic illness care. The article, written by Sheila Leatherman, Donald Berwick, et al., found only limited evidence that quality improvement initiatives undertaken by a set of health care providers could lead to a return on investment. (CHCS believes that the payment incentives in the overall health care system are misaligned with clinical best practices.) In response to the article, CHCS wanted to prove that a business case for quality exists in Medicaid, so in late 2003, it issued a call for proposals in search of “quality-enhancing initiatives” that demonstrate whether or not “quality pays” in Medicaid. CHCS staff view the Business Case for Quality (BCQ) as hugely important, and they hope to make the initiative one of their “signature products.” CHCS says the BCQ represents a sea change in its grant making strategy; future grant solicitations will use a targeted approach that can be highly leveraged.

5. Diffusing CHCS work

CHCS has decided to focus most of its resources on the leading states and health plans, which it labels the “innovators” and “early adopters.”⁹ By working with early adopters in BCAPs and Purchasing Institutes, CHCS hopes that quality improvement among this select group can “tip” their peers across the country toward a greater commitment to quality improvement. CHCS believes this will move its resources to where it has the most leverage and where it can affect the greatest change. CHCS says it hopes to continue working with less advanced states to improve their infrastructure and imbue them with the confidence to realize their potential. Presumably, most of CHCS’ attention will be focused on the innovators and early adopters. Striking a balance between these two approaches would be an important step for diffusing the CHCS brand name beyond the group of states that work most closely with CHCS.

CHCS has started to debate the best strategic method for diffusing its work, and how it can develop less advanced implementers of managed care into more advanced implementers. CHCS hopes to spread value-based purchasing practices through technical assistance provided to states and through its Purchasing Institutes. Participants at a BCAP advisory meeting held in March 2004 brainstormed methods to diffuse best practices. They determined that the most feasible option involved a mix of two methods:

1. Spread best practices via BCAP Collaboratives that bring together key stakeholders, including consumers and providers, to determine how they can contribute to quality improvement.
2. Spread best practices via external quality review organization (EQRO) vendors that help monitor and improve the quality of care for Medicaid beneficiaries covered under managed care. This “train the trainers” model is limited as a diffusion vehicle, because EQRO vendors may lack credibility, reliability, quality, and accountability. The Wisconsin EQRO is actually planning multiple BCAP-style activities in the state based on CHCS work.

This mixed method leverages the ubiquity of EQROs (which every state must have as a result of the Balanced Budget Act of 1997) while recognizing that BCAP (as a Collaborative) can work well for emerging clinical, social, and administrative areas. Another variation would be to build BCAP workgroups into the Collaborative, so a Collaborative would be run with the expectation that it would have a BCAP component.

The use of the BCAP advisory committee to make key strategic decisions highlights the evolution of the reliance of CHCS on advisory boards. During its early years, CHCS had a steering committee for BCAPs, Purchasing Institutes, and the Consumer Action agenda, but these were disbanded in 2002-03. Center staff say they have established good relationships with their external advisors, which has allowed the process to be more informal now and curtailed the need for additional committees. While in existence, the steering committees met about once per

⁹ CHCS adopted these terms after they were introduced and described in an article by Berwick, et al., *JAMA*, April 2003.

year and provided important direction for CHCS during its formative years. These steering committees were comprised of different stakeholders, including providers, consumers, health plans, states, and CMS staff. CHCS still uses external advisors, including the National Advisory Committee (or NAC, formerly the National Review Committee reflecting the earlier focus on grant review) and ad hoc advisors. The NAC has transitioned from its formal role focused primarily on grant making to an increasingly important role in providing feedback and shaping CHCS' overall strategic agenda. CHCS is moving to the point where it will only have one advisory committee, the NAC.

D. CHCS' VISION FOR ITS FUTURE: EXPAND ITS REACH, 2004 AND BEYOND

1. Demonstrate Quality in Medicaid Managed Care Extends to Medicaid More Generally

When CHCS was first created, it was formed around the MMCP and designed to improve the quality of the delivery of care in Medicaid managed care. Over time, CHCS has tried to establish its credibility, which has corresponded with a push by the organization to expand its reach and sights beyond the Medicaid managed care arena. CHCS slowly has become more ambitious in its goal setting. As early as 2000, it set an objective to become the “go to” resource for quality improvement in Medicaid managed care. In 2003, it broadened this goal to encompass quality improvement in Medicaid more generally. In 2004 and beyond, CHCS says it will continue its more traditional activities (including BCAP and Purchasing Institutes), while it tries to set its agenda or “squawk” more at the national level. CHCS says it sees an opportunity to leverage its work on Medicaid with other sectors—Medicare, commercial, and the uninsured—as its ultimate long-term goal, and hopes to capitalize on its Medicaid work to inspire broader quality reform.

2. Add Provider Constituency

CHCS plans to realign its key constituencies in the years ahead. CHCS has identified health care providers as the fourth pie piece or constituency that needs to be better incorporated into CHCS activities. CHCS is in the process of determining how best to trigger provider participation in its activities and to affect provider behavior. It wants to partner with organizations that work on national quality improvement efforts—such as ICIC, IHI, and the National Initiative for Children's Healthcare Quality (NICHQ)—that offer the opportunity to target providers. Right now it is unclear what effect these partnerships will have on CHCS.

E. TRENDS IN BUDGETING AND STAFF ORGANIZATION

1. Recent Budget Trends

The Center for Health Care Strategies has received \$62 million for the MMCP from its inception in 1995 through 2004. While much of these funds were awarded in the 1990s, more than \$30 million has been available to support operations from 2002 forward. RWJF last renewed the MMCP in July 2002 and authorized \$30 million in funding over a three-year period though only \$10 million reflected new funding. The rest of the funds were consolidated from unspent funds available from previous MMCP grants. This authorization was significant because RWJF consolidated the different MMCP funding streams (e.g., technical assistance, and

grant making) into one authorization thereby lessening financial reporting burden and increasing the flexibility to use grant and technical assistance strategies synergistically. Subsequently, the MMCP received a no-cost extension for an additional two years so that renewal—originally anticipated for June 2005—would instead be considered in June 2007.

In July 2002, CHCS also returned \$750,000 to RWJF expressly for underwriting the independent evaluation of the MMCP. This was the first in a series of no-cost extensions to which CHCS accommodated through its decision to scale back its grant making under the MMCP.

As mentioned in a previous section, CHCS has received small amounts of other funds from RWJF since its inception for a variety of purposes, most related to issues with similarities to those in Medicaid managed care. However, at least 80 percent of all CHCS funding since inception has originated from the MMCP funding stream.

2. Staffing Trends

Over the last few years, CHCS has experienced staff turnover as long-term staff have left for a variety of reasons and new staff have been hired, while relying on a few mainstays at the top. Stephen Somers has been President of the organization since its inception, and his responsibilities include providing overall direction to the program, each of its special projects, and grant making activities. His presence has helped maintain continuity as other staff have turned over. Karen Brodsky was Vice President for Program from inception until she left CHCS in early 2002. Her primary duty was to oversee day-to-day management of the program. Nicolette “Nikki” Highsmith who has been with CHCS since 1999 and was Director of Policy in 2002, ultimately filled Karen’s position.

Personnel in other positions also have remained with CHCS for an extended period of time, including Susan Fares, Director of Administration, and Patricia Barta, Senior Program Officer.¹⁰ However, other staff members have left, most notably Margaret “Peggy” Oehlmann, a Program Officer, who served as liaison to designated applicants, grantees, NAC members, RWJF staff, and consultants. She left CHCS at the end of July 2003, although she initially stayed on as a consultant. In addition, Seth Klukoff, most recently the Vice President for Operations, left CHCS in October 2004. Lorie Martin, who has been with CHCS since 1999, was promoted as Communications Director.

With headquarters in Princeton, New Jersey, CHCS is faced with the difficulty of attracting talent to a non-urban area. Despite this handicap, CHCS has assembled an impressive leadership team. CHCS recently made several key additions to its staffing, which have coincided with a reorganization of the center structure to fit evolving and expanding operations. Jane Deane Clark, Director of Evaluation and Analysis, joined CHCS in 2003. She is responsible for CHCS' research agenda, including the Business Case for Quality in Medicaid Managed Care, and all aspects of evaluation and measurement for CHCS. Deborah Bradley Kilstein,

¹⁰ Demetira Taitt, who started working as Financial Analyst in 2001 and was promoted to Director of Finance in 2003, has provided expertise in the finance area.

formerly the chief of staff for the New Jersey Department of Human Services, was hired as Director of Program Management in 2004. She is responsible for coordinating daily operations of CHCS' quality improvement programs for state Medicaid agencies and Medicaid health plans. John Kaelin who had 15 years experience in health care financing and program design became a Senior Fellow with CHCS in 2003 but left shortly thereafter during the first half of 2004 to take a position at United HealthCare. He had been leading CHCS' project on the Business Case for Quality in Medicaid Managed Care and had been engaged in a series of projects centered on quality measurement, improvement, and financing in managed care.

III. MAJOR FOCI OF THE MMCP, 2002-04

CHCS has designed activities around each of its three key stakeholders, including its two signature activities—the BCAP workgroup for health plans and the Purchasing Institute for state Medicaid staff. CHCS has invested much of its energy in recent years to find innovative ways to work with its key audiences, in particular plans and state staff, while maintaining and refining its older activities. CHCS has added many new initiatives in recent years that have grown out of its core activities.

A. WORK WITH STATES THROUGH PURCHASING INSTITUTES AND RELATED TECHNICAL ASSISTANCE

CHCS has used a mix of methods to work with state Medicaid staff in an effort to improve state’s institutional knowledge about how to be a competent purchaser of Medicaid services. The primary vehicle used by CHCS to reach state purchasers is the state Medicaid Purchasing Institute. CHCS has built off of this platform to offer a technical assistance series, funded by the MMCP, and various related activities funded through non-MMCP monies.

1. State Medicaid Purchasing Institute

a. Overview of the Purchasing Institute’s Development

The CHCS Purchasing Institute, formerly the State Medicaid/CHIP Purchasing Institute or SMCPI, aims to help state Medicaid and SCHIP staff members “improve their purchasing skills to respond to the evolving managed care marketplace.”¹¹ Despite some exceptions (such as the support given to California’s independent Healthy Families program), the emphasis in SCHIP programming has been primarily limited to SCHIP programs operated within Medicaid agencies.¹² At the outset, a steering committee consisting of state officials and other stakeholders provided guidance to these purchasing activities. The concept paper describing the Purchasing Institute, dated July 8, 1999, defined four objectives:

1. To design and implement a curriculum useful to a range of state staff, from policy-oriented staff to more technically oriented staff (such as rate-setting staff and contracting managers)
2. To work with the steering committee and others to make sure the curriculum is responsive to state officials’ learning and information needs

¹¹ It is run by Center staff members Nikki Highsmith, working with Center director Stephen Somers and James Verdier of MPR, support staff, and various institute faculty members on a contract basis.

¹² Early experience mixing standalone and Medicaid-operated SCHIP programs revealed that the two faced different issues and needs. Standalone SCHIP programs often operated more like commercial products. In contrast, the needs of those built on the Medicaid model tended to be more similar to Medicaid programs.

3. To help state officials address and resolve specific managed care purchasing problems and concerns
4. To serve as an ongoing resource of current information and technical assistance on managed care purchasing issues

The concept called for holding a series of two- to three-day seminars with continued work over the course of a year to offer targeted problem solving and technical assistance on topics such as capitation rate setting. Each seminar would bring together 30 to 50 participants, including state officials at different staff levels from a limited number of states. States desiring to participate need to commit to having multiple staff from the state attend, including top leadership, because this form of active participation is viewed as critical to having an ultimate impact within a state. Before each seminar, each state team would provide information on one problem area that fit within the institute's scope. Under the original plan, each cohort of participating states would engage in a year-long series of seminars that would increasingly focus on solving the identified problems and providing needed technical assistance. Written products and ongoing technical assistance would be targeted to the various groups of states. At year's end, Center staff would develop brief summaries of the issues addressed in the seminars for presentation in a "mini-case study" format (omitting sensitive state information) that would be made available to all states.

In its 2001 short-term assessment, MPR found that participants universally viewed the Purchasing Institute as a positive and unique opportunity not otherwise available to them. Participants found particularly helpful features such as the small, strategically constituted group, the team concept, the focus on managed care, and the emphasis on "nuts and bolts" at the operational level. The authors also concluded that it would be useful to refine the program and better articulate the Purchasing Institute concept and operational design to address more fully the diversity of state interests, needs, and priorities for reform, thus creating a structure that supports institutionalization of the institute initiative into a resource for states.

CHCS has sponsored four Purchasing Institutes to date and is planning a fifth institute.¹³ The first Purchasing Institute was convened in Princeton, NJ in March 2000. The program was limited to 50 participants selected from a variety of states in state-based teams of two to three staff members with different levels of responsibility. States seeking to send teams to the institute had to submit a consolidated application that indicated who would attend, one or two major purchasing issues faced by the state, and what the state expected to gain from its participation. The states also had to pay or arrange for travel expenses.¹⁴ Participants came from 14 states, with the number of participants per state ranging from a high of six, with most state teams consisting of two to four staff members. The curriculum was relatively broad and included

¹³ This number quantifies the Purchasing Institutes funded under the MMCP only. Other foundations have sponsored their own institutes, as described later in this chapter.

¹⁴ The intent was to encourage participation among states committed to the institute, with the assumption that most states could manage to secure travel funds even though these funds tend to be constrained. Most states used their own funds for travel, but some participant travel was funded by local sponsors. The center staff helped three states secure scholarships to attend from these regional foundations. Provisions for hardship exemptions were in place for subsequent institutes.

sessions in four core skill areas: (1) basics of managed care purchasing, (2) overview of capitation rate setting, (3) assessing network adequacy, and (4) monitoring access, quality, and performance. Some sessions allowed states to share best practices and innovative purchasing approaches (such as performance incentives, use of data, and risk adjustment). Targeted sessions focused on purchasing for special needs populations or programs for special populations (such as wrap-around services, managed long-term care and community-based care, advanced primary care case management, operational issues in coordinating Medicaid and SCHIP, and managed behavioral health). In addition, several managed care officials provided their perspectives in a series of presentations.

The second Purchasing Institute was held in November 2000 with 14 states represented, 8 of which also attended the first Purchasing Institute. In December 2001, 12 states were represented at the third Purchasing Institute in Berkeley, California, which was co-sponsored by the California HealthCare Foundation and focused on improving Medicaid and SCHIP operations.

The fourth Purchasing Institute took place in Colorado Springs, Colorado in November 2003. Of the 16 states participating, six had not previously attended a Purchasing Institute.¹⁵ For this workshop, CHCS required states to submit action plans, which were grouped into three main themes that were emphasized during the meeting: (1) managed long-term care; (2) expanding managed care to the aged, blind, and disabled (ABD) and SSI population; and (3) chronic illness care/disease management/pharmacy. According to CHCS, these are the emerging areas that states were interested in at the time.¹⁶ Individuals in managed long-term care and those in SSI compose a small portion of Medicaid participants but spend a disproportionate share of Medicaid expenditures. All three themes are more challenging and complicated than issues previously covered at Purchasing Institutes.

Follow-up after Purchasing Institutes has been limited though CHCS had intended to include it more aggressively in the fourth workshop. Before the Purchasing Institute, states submit action plans as a way to refine and distill issues and offer an opportunity for CHCS to provide technical assistance to states. At this Institute, CHCS asked for quarterly progress reports from states after the institute, but it has not been disciplined at following through on collecting them. CHCS staff acknowledges that there is a lag time, but it says it tries to ensure that states are doing what they proposed. CHCS plans to add more emphasis on technical assistance and follow-up at its fifth Purchasing Institute, “Leveraging Data to Reduce Racial and Ethnic Disparities in Health,” scheduled to be held November 4-5, 2004 in Atlanta, Georgia and funded by a combination of funds from the MMCP and the Commonwealth Fund.

While CHCS has not received formal feedback from states that attended a Purchasing Institute, at times, Center staff say that lessons learned from the events have led CHCS to redirect its focus. The latest Purchasing Institute in November 2003, along with the Managed Care Solutions Forum and one-on-one requests for technical assistance, initiated CHCS’ interest

¹⁵ New Mexico was one of the six states. While it had not previously attended a Purchasing Institute, it did participate in the technical assistance series held in Kansas City in September 2002.

¹⁶ According to CHCS, 10 states attended the break-out session on managed long-term care versus 3 or 4 states at the other sessions.

in pharmacy initiatives. CHCS' focus has been on clinical pharmacy management projects, rather than on drug pricing. CHCS is introducing two new pharmacy activities, a Pharmacy Benefit Design Resource Center and a Clinical Pharmacy Management Initiative, both of which are funded through the MMCP.

The Pharmacy Benefit Design Resource Center will provide an online center for states searching for information on developing Requests for Proposals (RFPs) for vendor services, running drug utilization review programs, or administering a pharmacy benefit. In the Resource Center, CHCS plans to provide access to model RFPs, studies and literature on the benefits and challenges of choosing benefit designs, and other tools to facilitate the decision-making process for state Medicaid staff. CHCS says that one-on-one technical assistance also will be available upon request.

The Clinical Pharmacy Management Initiative (CPMI) grew out of the 2002 Managed Care Solutions Forum, which met to discuss states' concerns over drug costs. Since then, CHCS has issued two reports on clinical pharmacy management programs and held a teleconference on the subject. A third report on behavioral health pharmacy issues is scheduled to be released in late 2004. The CPMI technical assistance program will work with 5 to 7 states interested in implementing programs involving pharmacy case management; physician and patient profiling and education; and disease management activities. CHCS convened its pharmacy advisory group and other experts in the field of clinical pharmacy management, disease management, and program design and evaluation, to discuss project and evaluation design issues. Originally, CHCS also planned to discuss at the meeting a Call for Proposals but later reconsidered. This meeting was held April 27, 2004 in Washington, DC. Under the CPMI, CHCS has published four reports and expects to release one additional report. CHCS says it will continue this initiative as it thinks more broadly about disease management in Medicaid and the impact of the 2003 Medicare legislation on Medicaid, particularly its impact on caring for dual eligibles.

All states participating in an MMCP activity, including Purchasing Institutes, are eligible to receive some form of technical assistance—by telephone, in-person meetings, or other forms of communication. Since 1999, CHCS staff has conducted nine one-on-one in-person technical assistance visits to eight states.¹⁷ Most of the technical assistance provided by center staff is done electronically or by telephone. More recently, CHCS has approached technical assistance differently than in the past when it provided technical assistance to any state that wanted it, generally for any relevant topic (and even for those states not participating in other CHCS activities). But CHCS found that this was not always effective, because, for example, the technical assistance did not always support the goals and objectives that CHCS and/or RWJF were working towards. They did it, however, to gain credibility in the states and to earn some name recognition for CHCS. Now, CHCS believes that it can be more selective in the technical assistance that it offers. CHCS says that future on-site visits will be consistent with CHCS objectives.

CHCS' goals around technical assistance to states are now focused on (1) being more efficient (with a more limited set of resources); (2) linking technical assistance to a broader set of

¹⁷ Indiana has received two on-site technical assistance visits.

CHCS/RWJF goals; and, (3) focusing resources on places where progress is most likely to happen. CHCS also sees its Managed Care Performance Technical Assistance Series (described in the next section) as a form of technical assistance, although the series does not provide assistance on an individual basis.

b. Technical Assistance Series

In 2002, CHCS switched strategies because of feedback from the short-term assessment and difficulties sustaining the delivery of customized technical assistance to states. Center staff said that individual technical assistance was too labor-intensive and resources were limited. One complicating factor was that states varied in their experience and level of sophistication with regard to value-based purchasing. Center staff acknowledged that they were unable to respond to all technical assistance requests. They also recognized the importance of balancing the needs of more and less advanced states while at the same time addressing issues common to all states. In addition, staff wanted to move beyond the broad-based overview that had defined the initial Purchasing Institutes. Though such a general approach had proved valuable in attracting states and bringing them up to speed, CHCS felt it important to move toward more active promotion of specific program change. As a result, CHCS changed its approach in 2002 and offered group technical assistance based on themes in which states demonstrate need. CHCS originally proposed a three-tiered approach that provides a series of technical assistance workshops focused on the following issues:

- ***Monitoring Managed Care Performance*** for states that do not have priorities for value-based purchasing
- ***Rewarding Managed Care Performance*** for states that have some initiatives in place and provide some incentives for improvement
- ***Improving Managed Care Performance*** for states that have a structure in place and are focusing on how to manage day-to-day improvements

CHCS implemented the first two of these series, but the Improving Managed Care Performance Series was abandoned and center staff say they have shifted these resources to other efforts such as the pharmacy initiatives. The two remaining series provide a framework for making organizational and design changes in managed care programs. States participating in the workshops must engage in planning and design, implementation, evaluation, and improvement activities in their home organizations. The workshops also focus on how states can track more systematically the progress and outcomes of the Medicaid and SCHIP programs.

For each series, between five to nine teams participate in three working meetings over one year. The first meeting is intended to focus on major questions concerning planning and design. The second meeting is intended to deal primarily with implementation issues, and the third meeting is intended to focus on evaluation and improvement of the project in the states' broader managed care program. Interim conference calls are held on an as-needed basis to discuss problems or issues that arise. The entire process emphasizes collaboration between participating states through meetings, listservs, and shared "homeworks." The details for both Purchasing Institute technical assistance series are discussed below. Table 1 summarizes the workshops held

TABLE 1

ACTIVITIES UNDER THE MANAGED CARE PERFORMANCE
TECHNICAL ASSISTANCE SERIES

Activity	Date	States Involved
Monitoring Managed Care Performance Series		
First Workshop	May 2002	California, District of Columbia,
Second Workshop	October 2002	Kansas, Massachusetts, Nevada,
Third Workshop	Cancelled	Virginia, and Washington
Rewarding Managed Care Performance Series		
First Workshop	September 2002	Arizona, Georgia, Maryland,
Second Workshop	Cancelled	New Mexico, North Carolina,
Third Workshop	Cancelled	Oklahoma, Texas, Utah, Vermont, and Wisconsin
Improving Managed Care Performance Series	Cancelled	

to date and the states that are involved in each. CHCS plans to provide additional workshops for both managed care performance series in the future.

Monitoring Managed Care Performance Series. The Monitoring Managed Care Performance series helps states develop an effective performance monitoring system for Medicaid managed care programs. Specific activities that states are expected to undertake include developing an inventory of current performance measures, establishing priorities for measures by aligning them with the goals of major managed care stakeholders, assessing measures based on the burden and utility of information for internal and external stakeholders, determining which measures can best help states assess and communicate the MMCP's impact, and developing and implementing internal and external performance reports with reliable evidence of improved operational and programmatic outcomes.

The first workshop in this series was held on May 22 and 23, 2002, in New Orleans. Participants came from seven states that had expressed interest (see Table 1). During the first day, CHCS staff gave an overview of the technical series' purpose and goals, the rapid-cycle quality improvement process, and the expectations for state participation and commitment. Each state then delivered a 10-minute presentation on its program goals and linkages to Medicaid and SCHIP managed care program goals, specific barriers and opportunities, and current data-collection efforts. The state presentations were followed by a presentation on Wisconsin's experience in developing a performance monitoring system. On the second day, a group discussion focused on how to prioritize and build the most effective performance monitoring system, a presentation described how to link requirements to the audiences' priorities and needs, and state teams reviewed and completed performance monitoring plans. The workshop ended with a discussion of next steps and how to engage in action planning.

The second workshop took place on September 17 and 18, 2002, also in New Orleans. Sessions focused on selecting effective performance measures, the best ways to standardize measures to allow performance comparisons across plans, how to finalize performance measures

and benchmarks to be used in the states' final report, and how to convey performance information to internal and external audiences. The third workshop in the series was cancelled. As a result of the series, five states have published internal and external monitoring reports.

Rewarding Managed Care Performance Series. The Rewarding Managed Care Performance technical assistance series outlines the major elements of an effective performance incentive system for Medicaid and SCHIP managed care programs. The goal of the series is to help states develop a performance improvement plan that promotes improved health plan and provider performance, establish baseline performance data and targets for each measure, link incentives and/or disincentives to health plan and provider performance, create a communication plan that fosters continued performance improvement, and establish budget strategies that finance the program and legislative strategies that facilitate external support.

CHCS convened one workshop under this series, which took place on September 30 and October 1, 2002, in Kansas City, Missouri. The workshop began with an overview of the technical assistance series' themes, the rationale behind using incentive programs, and the commitments necessary to ensure success. The next session focused on the types of data that can most strategically be used in performance incentive programs and included state team meetings to set performance targets and share information. The second day featured a session on how to devise an incentive program that focused on quality improvement as well as small-group discussions wherein state teams proposed strategies that apply incentives to specific measures to enhance performance and a presentation on how best to involve and communicate to stakeholders throughout the process. CHCS cancelled the two follow-up workshops in the series, because the impact of the Medicaid financial crisis has led many states to pursue non-financial incentive programs.

c. Use of State Experience and Purchasing Institutes as a Base for non-MMCP Funded Activities

CHCS has used its experience working with states at Purchasing Institutes and through technical assistance to implement related activities and programs that are funded using non-MMCP monies, including three additional Purchasing Institutes. Like the MMCP activities, these are designed to improve value-based purchasing skills within states.

Funded by the Annie E. Casey Foundation, CHCS has established the Children in Managed Care initiative, which provides technical assistance, training, and grant support to public purchasers and health plans to facilitate improvements in the delivery of services to children with special needs. In November 2001, the program sponsored a Purchasing Institute, called Integrating Care for Children with Special Needs, which was designed to help states develop and improve purchasing strategies for children and adolescents with special needs and their families.

The Technical Assistance Collaborative is sponsoring two Purchasing Institutes as part of Resources for Recovery: State Practices that Expand Treatment Opportunities, a national grant program of RWJF. The \$3 million competitive program encourages states to identify, support, and implement financing strategies to expand alcohol and other drug treatment services within existing state spending levels. CHCS has received \$659,000 to run the two Purchasing Institutes. The first Purchasing Institute, Financing Practices to Improve Substance Abuse Treatment, was

held in September 2003. A second Purchasing Institute on the same topic is planned for June 2005.

CHCS also has one other program oriented toward state purchasing that is funded by RWJF but not through the MMCP. The State Action for Oral Health Access, a \$1.7 million program run by CHCS, works with six states to develop projects that demonstrate improvement in access to oral health services for Medicaid and SCHIP participants with special health care needs. Under this initiative, CHCS plans to conduct a Best Practices Institute in 2005 that will be focused on states, the dental community, the public health dental community, providers, and policymakers. CHCS will be partnering with the American Dental Association in this effort.

B. WORK WITH HEALTH PLANS

CHCS' work with health plans began with the Best Clinical and Administrative Practices initiative as a program to enhance the ability of Medicaid/SCHIP health plans to provide quality care within public budgetary limits. According to the center's Web site, participants in the BCAP initiative include more than 100 health plans and primary care case management programs representing more than 13.5 million Medicaid beneficiaries. Over time, CHCS' work with health plans has broadened to include an array of other related activities that complement BCAP, such as the Quality Summit and the multi-constituent Collaborative.

1. Overview of BCAP's Development

The concept behind BCAP is premised on the idea that health plans lack sufficient opportunities to come together and consider best practices. The overarching strategy seeks to convene work groups of leaders from health plans across the country to develop and replicate best practice models in Medicaid managed care. BCAP thereby becomes a vehicle for more actively engaging Medicaid managed care plans in the MMCP. The program is modeled after the Breakthrough Series for providers convened by Donald Berwick of the Institute for Healthcare Improvement (IHI). Despite discussions about involving Berwick and his organization in the BCAP initiative, the talks did not yield any results, with one point of tension perhaps the trade-off between model replication and tailoring the model to the particular characteristics of Medicaid managed care. Another point of tension would be the focus on managed care organizations versus providers. Unlike the Breakthrough series, BCAP emphasizes change at the plan level rather than at the provider level.

The BCAP initiative is based on a typology that offers a consistent template for designing quality initiatives that can be customized to address specific clinical and administrative needs. The four steps of the BCAP typology are:

1. **Identification:** How do you identify the relevant population?
2. **Stratification:** How do you assign risk within that population?
3. **Outreach:** How do you reach the target population?
4. **Intervention:** What changes will you make to improve outcomes?

Each BCAP participant must follow this four-step program. CHCS has a two-part objective: (1) diffuse use of the typology and (2) diffuse use of the best practice.

At the initiative's outset, a steering committee of state purchasers, health plans, and foundation staff was established to identify key BCAP topics and priorities.¹⁸ The program model depends on the continued commitment of a core workgroup of health plans that meet over nine months to work on a particular topic area, with an additional three months at the end of the period for conference calls and technical assistance. The program covers attendees' travel costs. Participants are asked to:

- Participate in workgroup meetings to discuss and develop a best practices typology
- Pilot the developed typology in each participant's plan
- Participate in follow-up conference calls with BCAP facilitators and CHCS staff
- Serve as faculty for CHCS in its efforts to provide technical assistance to other Medicaid/SCHIP managed care organizations (MCOs)

The workgroups produce a toolkit that they make available to interested Medicaid/SCHIP MCOs. CHCS provides toolkit training and technical assistance to staff from groups of 25 to 30 MCOs at a time. The steering committee determined the workgroup topic priorities based on both the topics' relevance to beneficiaries and the likely payoffs from intervention by health plans within a reasonable period of time. The longer-term goal is to strengthen MCO capacity to provide high-quality care within capitations set under public budgetary limits and with attention to state purchaser requirements and relationships.

CHCS recruits plans aggressively, focusing on MCOs with at least 20,000 Medicaid/SCHIP enrollees to ensure that the programs remain an important line of business for the plans. They also seek diversity in factors such as geography and plan type.

To date, CHCS has formed BCAP work groups on five topics: (1) Toward Improving Birth Outcomes, (2) Improving Preventive Care Services for Children, (3) Achieving Better Care for Asthma, (4) Improving Managed Care for Children with Special Needs, and (5) Improving Care for Adults with Chronic Illnesses and Disabilities. BCAPs 6 and 7 are not funded through the MMCP. BCAP 8, Improving Health Care Quality for Racially and Ethnically Diverse Populations in Medicaid Managed Care, will be supported by a combination of funds from the MMCP and the Commonwealth Fund. CHCS expects BCAP 9 to be funded solely through the MMCP. Table 2 shows the specific BCAPs that have been offered and the timing of the workgroup activities and follow-up workshops and toolkits.

MPR's short-term assessment of the BCAP initiative, based on experience in BCAP #1, revealed that participants generally find the experience valuable and rewarding. The authors concluded that BCAP's main weakness was a lack of clear expectations about workgroup goals

¹⁸ The steering committee later was disbanded.

TABLE 2

ACTIVITIES UNDER THE BEST CLINICAL AND ADMINISTRATIVE PRACTICES PROGRAM

Toward Improving Birth Outcomes	
First Workgroup Session	April 2000
Second Workgroup Session	July 2000
Third Workgroup Session	December 2000
Workshop and Toolkit	October 2001
Improving Preventive Care Services for Children	
First Workgroup Session	October 2000
Second Workgroup Session	January 2001
Third Workgroup Session	June 2001
Workshop and Toolkit	March 2002
Achieving Better Care for Asthma	
First Workgroup Session	April 2001
Second Workgroup Session	July 2001
Third Workgroup Session	December 2001
Workshop and Toolkit	November 2002
Improving Managed Care for Children with Special Needs	
First Workgroup Session	November 2001
Second Workgroup Session	February 2002
Third Workgroup Session	July 2002
Fourth Workgroup Session	December 2002
Toolkit	Spring 2004
Improving Care for Adults with Chronic Illnesses and Disabilities	
First Workgroup Session	May 2002
Second Workgroup Session	September 2002
Third Workgroup Session	January 2003
Fourth Workgroup Session	April 2003
Toolkit	Summer 2004
Quality Summits	
First Quality Summit	October 2002
Second Quality Summit	March 2004

and outcomes, along with some concern that evidence-based knowledge was lacking in critical areas of concern to BCAP.

CHCS has since refined the BCAP process's concepts and expectations, modifying its guidelines to further clarify the goals for each plan and for BCAP in general. Further, a major change introduced to the BCAP process was the addition of a 12-month extension period at the conclusion of each workgroup. Each BCAP now has two phases: (1) the nine-month period for planning and early implementation and (2) the new 12-month period for implementation and evaluation. Continuation of the workgroup beyond nine months was intended to increase CHCS' ability to collect global outcome measures, provide health plans with CHCS' technical assistance, and allow CHCS to maintain relations with the health plans for the BCAP network. Finally, to address the issue of evidence-based knowledge, CHCS now facilitates discussions

with its workgroups to reach a common understanding of the degree to which each workgroup may draw upon evidence-based clinical practices available in the field.

CHCS began to develop a BCAP “Quality Framework” in 2003, using the BCAP typology as a foundation. The first three BCAPs aimed to spread the four-step typology (i.e., identification, stratification, outreach, and intervention), but CHCS felt that the process was missing an aspect of accountability from its participants. Thus, the BCAP Quality Framework, which CHCS rolled out at the Quality Summit held in March 2004, added three components in addition to the BCAP typology: rapid-cycle improvement, measurement and evaluation, and sustainability and diffusion.

The rapid improvement cycle involves four stages: plan, do, study, and act. It identifies an aim, measure, and change strategy for each step of the BCAP typology. The BCAP measurement and evaluation includes four steps: pilot specific process measures; develop common process and outcome measures; develop normative benchmarks; and develop team success, sustainability, and diffusion scales. CHCS wants to ensure that positive change from the BCAPs is institutionalized; therefore, CHCS intends to continue to spread the lessons learned from the BCAP Quality Framework and from the best practice itself. CHCS is encouraging plans to disseminate their work internally and spread the BCAP typology to other quality initiatives that the plan takes up. While this has always been a CHCS objective, CHCS now actively encourages plans to do more internal dissemination. As a result of the BCAP typology that CHCS has developed, CHCS believes some health plans have experienced a “culture shift” in quality improvement. For example, Molina Health Plan of Michigan is talking about diffusing the typology to its plans in other states too, and a dozen other health plans currently use the BCAP typology as their sole model for quality improvement.

2. BCAP Quality Summit

The Quality Summit offers health plans an opportunity to congregate and discuss quality improvement projects on a variety of clinical topics for the various populations served by Medicaid programs.

The first Quality Summit was held in October 2002 in Atlanta, Georgia. Participants represented about 50 health plans and included Medicaid health plan medical directors, quality improvement directors, key health plan staff, and health care researchers.¹⁹ Many of the attendees present came from health plans that had never participated in a BCAP. Most heard of the summit through the BCAP newsletters, and they indicated that they attended mainly to learn about BCAP and explore whether it was something in which their plans should get involved. The summit sought to inform attendees about quality improvement efforts of previous BCAP plan participants and how they achieved successful outcomes, help them apply the BCAP typology in developing quality improvement initiatives, help them establish effective measures, and enable them to network and share ideas and strategies with other Medicaid health plans.

¹⁹ This number excludes those individuals and organizations that participated as faculty only.

The second Quality Summit was held in March 2004 in New Orleans, Louisiana. Its theme was Caring for Children and Adults with Chronic Illnesses and Disabilities. This summit was open to a more diverse group of participants, including Medicaid health plans, PCCM programs, state Medicaid agencies, and other organizations committed to improving the quality of care for adults and children with chronic illnesses and disabilities. In total, the summit had 102 attendees, including participants from seven states, one external quality review organization (EQRO), a staff member from the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau, and other organizations such as the United Hospital Fund, the Arthritis Foundation of Pennsylvania, and Health Care for All (a consumer-based organization from Massachusetts).

The assembly of health plans provided CHCS with an opportunity to relate the conference to another activity, grant making. During the conference, health plans worked on applications for seed grant money to implement pilot projects from one of four tracks: (1) children with special health care needs, (2) adults with disabilities and chronic illnesses, (3) improving maternal, child, and adolescent health, and (4) achieving better care for asthma. The summit functioned more as a "working meeting" than a conference, because participants were busy working on their applications for seed grant money, which was due a week after the summit. This created a competition of sorts; health plans tended not to collaborate on ideas, at least within the confines of the working sessions devoted to the applications' development. Every health plan that develops a pilot project qualifies for technical assistance over the following year, regardless of whether the plan is awarded the seed money.

CHCS plans to convene a third Quality Summit in spring 2006 to communicate best practices from the initiative for improving care for racially and ethnically diverse populations in Medicaid and other insurance programs, and for chronic diseases that are prevalent across all populations. CHCS plans to develop and disseminate a toolkit cataloguing these promising strategies. The Summit will be jointly funded through the MMCP and the Commonwealth Fund.

3. Building on BCAP Work with Diversified Funding

CHCS has applied its expertise with health plans to activities funded through a variety of foundations. These include: additional BCAPs, multi-constituent Collaboratives, and other initiatives designed to assist health plans.

a. More BCAPs

Some foundations have been interested in applying the BCAP typology to a special topic and have contracted with CHCS to do so. The Commonwealth Fund sponsored BCAP 6, Enhancing Child Development in Medicaid Managed Care, which began in June 2002 and is scheduled to end in September 2004. The Annie E. Casey Foundation sponsored BCAP 7, Improving the Quality of Care for Adolescents with Serious Behavioral Health Disorders in Medicaid Managed Care, which began in August 2003 and is scheduled to end in December 2005. CHCS also has partnered with Children's Futures and HealthWorks Consulting to convene a BCAP on Improving Maternal and Newborn Health Care in Trenton, New Jersey, scheduled to last from November 2002 to September 2005. This collaborative of Trenton-based

organizations are cooperatively developing and piloting strategies to more effectively deliver medical and social services to pregnant women and their newborns.

b. Collaborative Approach to Quality Improvement

With an initial \$120,000 development grant from the David and Lucille Packard Foundation, CHCS has created collaboratives that bring together a diverse cast of constituent groups to develop and implement best clinical and administrative practices. So far CHCS has organized two collaboratives on asthma and one collaborative in Indiana to incorporate a value-based purchasing focus into its Medicaid managed care programs. CHCS also is searching for additional opportunities.

The California Asthma Collaborative, a \$344,000 project funded by the California HealthCare Foundation, brings together state Medicaid officials, 11 health plans, providers, and consumer organizations to design and implement strategies to improve clinical quality of asthma care. According to CHCS, the collaborative will focus on two major goals: establishing practices that improve clinical quality for enrollees with asthma, and maximizing limited resources by coordinating interventions and sharing information across stakeholder groups. Several participants were previously involved in a BCAP or Purchasing Institute. CHCS has convened a workgroup, to which it has applied CHCS' multi-component measurement strategy (as previously described). CHCS will facilitate workgroup communication and collaborative problem solving through meetings, group conference calls, and individual team technical assistance. Team successes will be described in an issue brief that will be disseminated throughout the state as well as to other states seeking to adopt a collaborative approach to quality improvement. The health plans in the Collaborative have agreed to report on standardized measures of asthma care and will be reporting a minimum of three years of data to assess trends in asthma quality and access.

CHCS began two additional Asthma Collaboratives, one in New York State and one in Indiana, funded by RWJF (though not through the MMCP). The \$485,000 project will form a collaborative team that includes health plans, state Medicaid officials, provider representatives, and consumer organizations to improve care for Medicaid enrollees with asthma. The project began in September 2002 and will end in June 2005, four months after the original end date. The 12 participating health plans in the New York State Collaborative will report the same measures as the California Collaborative.

In Indiana, CHCS has established a Collaborative to help the state set consistent quality improvement standards for its health plans by including the BCAP Quality Framework in its plan procurement requirements as the preferred quality improvement approach. CHCS technical assistance also is helping the state to develop value-based purchasing tools, including monitoring and incentive payments. In 2005, the state will be using the BCAP Quality Framework to help Medicaid health plans integrate with the Indiana Chronic Disease Management Program, which is designed to improve the quality of health care for people living with asthma, diabetes, and congestive heart failure. CHCS and the McColl Institute for Health Care Innovation, RWJF's ICIC grantee, will work with Indiana Medicaid staff, health plan leadership, and local physicians to implement a sustainable model of care for people with these three chronic conditions. A CHCS-led state/health plan BCAP Collaborative will focus on how to engage providers, incorporate consumer and community feedback, and build cultural competency into quality

improvement programs. CHCS and McColl are working on a similar cooperative arrangement in California.

c. Other Initiatives to Assist Health Plans

Improving Asthma Care for Children is an RWJF-funded program (not through the MMCP) that works with five health plans to improve the management of pediatric asthma under managed care in high-risk recipients of Medicaid and SCHIP. RWJF has donated \$1.4 million to fund technical assistance and direction for the four-year program, which began in October 1999.

CHCS, with \$402,000 in funding from the California HealthCare Foundation, has partnered with the eight Local Initiative managed care plans serving Medi-Cal and Healthy Families enrollees in California's nine "two plan model" counties. The project lasts from February 2004 to November 2005. Under Local Initiative Rewarding Results, the health plans are participating in a collaborative project to test how financial and non-financial incentives impact provider quality. The project seeks to improve the quality of and access to preventive care services for children and adolescents by increasing the rate of annual adolescent visits and preventive care visits for infants from birth to 15 months of age. Incipient work was done in a related project; Academy Health provided \$45,000 for CHCS staff to provide technical assistance to nine Medicaid health plans in California, beginning in June 2002.

C. WORK WITH CONSUMERS THROUGH THE CONSUMER ACTION AGENDA

The purpose of the Consumer Action Agenda is to (1) help consumers and their families navigate publicly financed managed care systems and (2) establish a formal role for consumers in the design, implementation, and evaluation of publicly financed managed care programs so that they are responsive to consumer needs. Funds from the Annie E. Casey Foundation's Children in Managed Care Initiative complement those from the MMCP to support the Consumer Action Agenda. A steering committee was created to guide CHCS' work on the Consumer Action Agenda, although it later disbanded as CHCS has come to rely on input from the NAC and other informal advisors. The committee had seven members, including staff from major national consumer groups and diverse locally-based programs. The two activities that the committee focused on were a consumer leadership meeting held in 2000 and the development of the consumer action seed grants, the primary vehicle for advancing CHCS' Consumer Action Agenda. The first round of seed grants of up to \$25,000, issued to 10 grantees, were developed as an effort to support innovative projects that strengthen consumer and family understanding of and involvement in publicly financed managed care.

MPR conducted its short-term assessment of the MMCP just as CHCS was soliciting proposals for the first round of consumer action grants. MPR conducted a mini-case study on the Consumer Action Agenda and interviewed the chair and four other members of the steering committee in an effort to provide insight into the strategic positioning of the Consumer Action Agenda and areas for future attention. The assessment found that there was strong support in the advocacy community for funding work on consumer issues and managed care and that CHCS possessed the ability to fill the void in this area. However, there was concern that bureaucratic inertia, political resistance to a real role for consumers, and the history of "tokenism" in dealing with consumers would limit success of the consumer action grants. There was also concern

expressed over the small size of the grants and the absence of an infrastructure that would extend and institutionalize the work begun under the grants. The assessment recommended that CHCS use the grants as a laboratory or catalyst to encourage future action and outside funding of consumer priorities.

CHCS explored the potential to create a National Association of Medicaid/SCHIP Beneficiaries (NAMSB). Nancy Turnbull developed a report to determine the idea's feasibility. Because of the divided nature of consumer organizations in Medicaid, the lack of national leadership, and difficulties in funding the ongoing work of such an association, CHCS considered the notion of creating NAMSB to be dubious at best.

1. Consumer Action Grants

In early 2001 (prior to the first MPR assessment), CHCS solicited proposals from consumer and family organizations for the consumer action seed grants. Proposals were also accepted from community organizations that demonstrated a commitment to helping consumers understand and influence the design of health and health related services. For consideration, applicants had to be located in areas with a substantial volume of publicly financed health care and behavioral health care. While the grant's main focus was on local action, CHCS hoped that the grants would generate findings that could be communicated and used more widely. Nineteen organizations received grants, including 10 that were local initiatives under RWJF's Covering Kids Initiative.

Grantees were allowed to use the consumer action grants to support project staff salaries, consultant fees, office operations, and other direct expenses, including travel and purchasing a limited amount of essential equipment. Grantees were not allowed to use the funds to subsidize individuals directly for the cost of their care, construct or renovate facilities, or as a substitute for funds currently being used to support similar activities.

In 2002, CHCS funded another round of grants and increased the maximum dollar amount to \$50,000. In this round of grants, CHCS' goals for the projects remained the same, but CHCS targeted its solicitation to projects that focused specifically on disabilities and chronic illnesses. Ten organizations received grants. The second round of grantees received more technical assistance from Center staff than the first received. Although CHCS provided some form of technical assistance to all grantees, it recognizes that grantees could still use more. Table 3 lists all the grantees, each project's award amount, and the month of award.

Most of the grantees from both solicitations were private not-for-profit organizations that classified themselves as consumer organizations, advocacy groups, or family support organizations. In addition, most grantees worked on one of five types of primary activity: (1) education seminars for consumers designed to improve consumers' navigation skills and/or advocacy skills, (2) development of written materials to help consumers navigate Medicaid managed care or improve policymaker understanding of system barriers, (3) arranging for consumers to collaborate with policymakers, providers, or health plans, (4) consumer peer mentoring, and/or (5) advertising or expanding a consumer assistance telephone line. Of those five primary activities, grantees most frequently focused on educational activities and development of materials.

TABLE 3
CONSUMER ACTION GRANTS AWARDED

Organization	Amount	Date of Award
Agenda for Children*	\$25,000	September 2001
Alliance for Fairness in Reforms to Medicaid	\$25,000	March 2001
Berkshire Area Health Education Center	\$24,999	August 2001
Bitterroot Conservation and Development Area, Inc.*	\$25,000	September 2001
Campaign for Better Health Care	\$25,000	August 2001
City of Bloomington*	\$25,000	September 2001
Colorado Cross-Disability Coalition	\$50,000	October 2002
Community Services Planning Council, Inc.	\$48,219	October 2002
Consumers for Affordable Health Care*	\$25,000	September 2001
DC Action for Children Today*	\$25,000	September 2001
Family Service Woodfield, Inc.*	\$24,650	August 2001
Federation for Children with Special Needs, Inc.	\$50,000	October 2002
Gay Men's Health Crisis	\$25,000	August 2001
Health Care for All, Inc.	\$50,000	October 2002
Human Services Coalition of Dade County*	\$25,000	September 2001
Maine Parent Federation, Inc.	\$50,000	October 2002
Massachusetts Consumer Satisfaction Team	\$24,940	August 2001
Mental Health Association of Southeastern Pennsylvania	\$50,000	October 2002
Mental Health Client Action Network	\$48,498	October 2002
Ocean State Action Fund	\$25,000	August 2001
Oregon Health Access Project*	\$25,000	September 2001
Oregon Health Access Project	\$50,000	October 2002
Outside In*	\$25,000	September 2001
Patient Advocacy Coalition	\$25,000	August 2001
Statewide Parent Advocacy Network	\$25,000	August 2001
Support for Families of Children with Disabilities	\$24,776	August 2001
The Council on Mental Retardation, Inc.	\$50,000	October 2002
Tohono O'odham Nation Department of Human Services	\$49,866	November 2002
Western Maryland Health Education Center*	\$23,353	September 2001

*Represents projects funded under RWJF's Covering Kids Initiative.

Since CHCS' second solicitation of consumer action grants, it has independently changed course and stopped providing pure grant making for consumer organizations, which it believed were not especially effective. Instead, Center staff say they plan to focus on providing technical assistance and training, but there have been few resources committed to this and CHCS says it is reconsidering the current direction of the Consumer Action Agenda, including how to document consumer issues around best practices, how best to intervene and work with consumer-based organizations, and how best to provide technical assistance to these organizations that is comparable to what it developed for states and health plans. Eventually CHCS says it hopes to progress to evidence-based practices, but consumer organizations are not yet that sophisticated. For the time being, CHCS has not been very active in pursuing other activities with consumers. CHCS views the consumer role as a conundrum that has yet to be solved. CHCS believes that it might not be the organization best suited for promoting consumer action in Medicaid managed care, but it intends to find out, in particular through its experience with the Covering Kids and Families-Access Initiative (CKF-AI) described below.

2. Non-MMCP Activity Targeted to Consumers

RWJF employed CHCS to run the Covering Kids and Families-Access Initiative, using non-MMCP funds, although CHCS has used MMCP funds to support the national program office and technical assistance functions. The \$3.2 million grant works with community-based organizations to improve access to health services for children and adults enrolled in Medicaid and SCHIP.²⁰ For Phase I of the initiative, CKF-AI awarded 18 grants of \$125,000 and one of \$150,000 to local pilot projects to identify and document barriers to the use of health care services for low-income children and adults. RWJF also gave CHCS \$800,000 of special technical assistance funds, which includes \$20,000 that were disbursed to state-level advocacy organizations for Phase II of the project. These organizations are supposed to help the local CKF-AI grantees in Phase II to develop and implement strategies that address specific barriers to care identified in Phase I. CHCS views the CKF-AI as an experiment to help determine how successfully it can provide training and technical assistance to consumer organizations, which is consistent with CHCS' view that grant funding alone is not sufficient to create change.

²⁰ The program authorization was for \$4 million; however, not as many grants were awarded as originally anticipated because of the quality of applications.

IV. DEVELOPMENT OF CROSS-CUTTING INITIATIVES

Many of CHCS' core functions cut across more than one of its main audiences. These components include grant making, communications, and publications, which have evolved in parallel to those activities that involve direct work with the three key stakeholders. While CHCS has concentrated on nurturing its "direct" activities, CHCS also has developed cross-cutting initiatives to promote more collaboration and capitalize on synergies across its main audiences.

A. GRANT MAKING

Aside from Consumer Action Seed Grants, CHCS historically has funded two main types of grants through the MMCP: (1) model demonstrations and (2) best practices.

- ***Model demonstration grants*** have provided up to \$250,000 in funding to state agencies, managed care organizations, and health care providers to support demonstrations.²¹ This grant program was created on the theory that state agencies and health plans have innovative ideas on how to improve managed care delivery but need funding to implement changes. The model demonstrations seek to foster improvement in the organization and delivery of care to vulnerable populations, with an emphasis on projects that can be replicated by other states and health plans. Model demonstration projects are expected to test innovations in service delivery and financing for people with chronic illnesses and disabilities.
- ***Best practices grants*** provide up to \$100,000 in funding to state Medicaid/CHIP agencies, health plans, consumer organizations, health services researchers, and policy analysts. Best practices grants can be further categorized into two types: planning grants and policy studies. Planning grants are awarded to state agencies and managed care organizations to develop, test, or refine "best practice" strategies to improve the delivery of managed care in SCHIP and/or Medicaid. These grants are typically given to help organizations plan for a full-scale model demonstration. Policy studies document best practices in management and operations of Medicaid and SCHIP managed care and/or provide analysis of market trends and federal, state, and health plan policies that impact the implementation and outcomes of Medicaid and SCHIP managed care. These grants are often awarded to develop materials and conduct research to support CHCS' technical assistance activities.

²¹ The ceiling for model demonstration grants was raised from \$500,000 to \$750,000 in 2002. CHCS can still make grants of 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 grants over \$250,000.

1. Overview of MMCP Grant Making

CHCS was initially established as a national program office to administer grants for the MMCP. Accordingly, grant making was the main focus of the MMCP, with particular emphasis given to model demonstrations. Grant making accounts for more than half of the resources that the MMCP has received over time. Of the nearly \$60 million in funding that CHCS has received for the MMCP during that period, \$32.5 million was earmarked specifically for grant making: \$14 million under the initial authorization (funding for 1995-1999) and \$18.5 million under the reauthorization (funding for 2000-2004). However, grant making's percentage of total funding has decreased over time. CHCS has chosen to divert money authorized for re-granting to underwrite additional training and technical assistance activities from 2003-2005. It also is using reductions in grants to support the funds needed to extend the program until 2007, delaying needs for renewal presently when funding is very tight at the foundation.

When the grants program was launched in 1995, CHCS established structures and processes that largely remain in place today, although CHCS' grant making strategy and approach has evolved within this original framework. CHCS uses its grants program as a vehicle to support innovation and to identify and disseminate best practices in publicly financed care. The grant making effort has always placed a high premium on the operational utility of a proposed project. In the following sections, we provide an overview of solicitations and awards from 1995 to the present, and then describe key changes in CHCS' strategy over that period. Table 4 highlights important milestones in the development of the MMCP grants program.

a. Solicitations and Awards, 1995-present

Since 1995, CHCS has issued six calls for proposals (CFP) for various MMCP grants.²² For its initial grant solicitations, CHCS used a mailing list developed by RWJF, which contained approximately 30,000 names of individuals and organizations, including governors, legislators, Medicaid directors, and health plans. Subsequently, CHCS winnowed the list to 2,000 individuals and organizations, primarily state Medicaid directors and health plans that contract with Medicaid.

Initially, CHCS awarded only best practices and model demonstration grants. Best practices proposals had quarterly deadlines before Board meetings while the larger model demonstration proposals were reviewed once a year.²³ One of the key structures CHCS put in place to support its grant making was a rigorous review process. CHCS established the National Review Committee (NRC—renamed the National Advisory Committee in June 2004), a group of Medicaid managed care experts, to review and approve grant proposals. To ensure broad representation of CHCS' primary audiences, CHCS enlisted health plan executives, state Medicaid directors, physicians, and health services researchers with expertise in consumer issues, purchasing, clinical and plan operations, and Medicaid policy to serve on the NRC.

²² This includes the Business Case for Quality in Medicaid, which is funded through a combination of funds from the MMCP and the Commonwealth Fund.

²³ CHCS began accepting model demonstrations on a rolling basis two years after program inception.

TABLE 4
HISTORY OF GRANT ACTIVITIES UNDER THE MMCP

Grant Activities	
Feasibility study grants attract 400 applications in first two years; only 26 applications received for larger grants in first round (July 1996)	November 1997
In first three years, CHCS awards 39 policy grants for \$2.4 million and 20 model demonstration grants for \$3.7 million	Fall 1998
CHCS begins implementing strategy of increasing linkage between grant making and technical assistance activities	1999
A five-year review indicates commitments of grant funds over the period distributed roughly one-third to policy studies and two-thirds to Model Demonstration Grants	October 2000
CHCS creates a task force to evaluate the grant-making and grant-monitoring processes	October 2001
CHCS issues a call for proposals targeting three topics for nine model demonstration grants: (1) managed care for children with special needs, (2) managed behavioral and general health coordination, and (3) managed long-term care	January 2002
From 2000 to 2002, CHCS awards 24 model demonstration grants and 47 best practices grants	November 2002
At a board meeting, CHCS sets the upper bound on model demonstration grants and best practice grants at \$250,000 and \$100,000, respectively. Grant making is shifted to a training and technical assistance component.	June 2003
CHCS issues a call for proposals on the Business Case for Quality in Medicaid for up to \$50,000.	November 2003
CHCS award 3 innovation grants of \$20,000 each after receiving proposals from the Quality Summit in May 2004	2004

The review process involves three stages: initial screening by Center staff, a second screening by the NRC, and final review and approval by the CHCS board. Center staff review all grant proposals for quality and relevance to the MMCP's goals. Promising proposals are forwarded to the NRC. Currently, a two- to three-person team from the NRC reviews each grant proposal.²⁴ For model demonstrations, Center staff or NRC members often conduct a site visit to assess the site's readiness for a full-scale demonstration. At the outset, all of the larger grants and some of the best practices grants were selected for review during a meeting of the full NRC. Over time, CHCS has come to rely on subsets to the NRC to conduct telephonic reviews of some large grants.

²⁴ For best practices proposals, the Center sometimes includes in the review team "outside" consultants who have particular expertise in areas related to the grant proposal.

As shown in Table 5, Center staff screen out many proposals, and those that are forwarded to the NRC have a high probability of being funded. Between 1995 and 2002, CHCS received a total of 107 proposals for model demonstrations and forwarded fewer than one-third (27 percent) to the NRC. Among those reviewed by the NRC, more than 85 percent were funded. Of the 928 best practices grant proposals received, only 25 percent were forwarded to the NRC. About two-thirds (68 percent) of those reviewed by the committee were funded. As of early 2003, MMCP staff spent less than 15 percent of their time screening and reviewing applications.

Discussions with Center staff revealed that proposals are rejected at the initial screening stage for three main reasons: (1) the proposal is not high quality; (2) the proposed project is unrelated to Medicaid managed care; or (3) the application requests funds for business development rather than replicable or nationally relevant process improvements to enhance service delivery. NRC members reported that model demonstration proposals were typically rejected because the ideas proposed were not innovative, the proposed project did not meet the standards of quality to merit the level of funding requested, or NRC members questioned the applicants' ability to implement the project. For best practices proposals, NRC members with experience in agencies and health plans indicated that rejected proposals often did not show enough understanding of the bureaucratic, operational, organizational, political, and financial dimensions of running a state program or managed care organization. Researchers on the committee commented that many of the rejected proposals did not demonstrate a good understanding of research methodology.

At the program's inception, CHCS staff, RWJF staff, and the NRC believed that the grants program would make its greatest impact through model demonstrations. The initial calls for proposals, however, yielded little response from the field. An internal RWJF assessment indicated that the initial solicitation drew just 26 proposals. Only one was deemed worthy of full funding; four received planning grants and three of these ultimately became full-scale demonstrations. Authors of the same assessment suggested three reasons for the lack of stronger proposals for model development. First, states were sufficiently challenged by the transition to managed care that developing new models, especially for the chronically ill, was not a priority. Second, the requirement that states collaborate with a managed care plan on the proposal was hard for states to do on a sole source basis because of their procurement rules. Moreover, the small amount of funding that would flow to the plan gave plans little incentive to participate. Third, having to submit a full proposal for a model demonstration grant without having first gotten feedback from a letter of intent was too burdensome for states. These results from the RWJF assessment led CHCS to re-think its grant making strategy.

b. Key Changes in Strategy

Although CHCS has maintained the basic structure of its grants programs, it has made some notable changes in its approach. CHCS' ability to change and improve its strategies was helped by changes in the way CHCS itself was funded. In the first round of funding from RWJF, funds were earmarked for specific grant programs, including \$10 million for model development, and \$4 million for best practices grants. During its 1999 reauthorization, CHCS received an additional \$18 million in grant funds, \$13 million of which was earmarked for model demonstrations and \$5 million for best practices. Over time, funding for the MMCP became more fungible. CHCS gained greater flexibility in how to allocate its funds: although 1999 funds were earmarked, CHCS was permitted to shift funding across priority areas (e.g., managed

TABLE 5
GRANT PROPOSALS RECEIVED, REVIEWED, AND FUNDED: 1995 – 2002

Grant Type	Number of Applications Received	Number Forwarded to the NRC for Review	Number Awarded
Model demonstration	107	29	25
Best practices			
Planning grants	108	46	33
Policy studies	820	182	121
Total	1,035	257	179

care best practices, informed purchasing, and consumer action), as well as across grant programs. CHCS used this flexibility to align its technical assistance and grant making activities to what was happening in the field. In particular, CHCS has worked to (1) build states’ and health plans’ capacity to undertake model demonstrations, (2) increase the synergy between its grants and technical assistance programs, and (3) target grants to specific priority areas.

Capacity Building. According to Center staff, it revised its strategy in 1997 and began to focus on building capacity in ways that might put states in a better position to undertake large model development and address the issues raised by the RWJF internal assessment. CHCS began awarding planning grants to states and plans whose proposed demonstration projects showed promise but that were not quite ready for implementation, allowing them to “work up” to developing major initiatives. The grants were intended to help organizations conduct further planning and research on best practices in the field to improve their readiness for a full-scale demonstration project. This approach has led to greater interaction between CHCS and potential grantees, allowing CHCS to provide more direction and offer feedback on the proposed projects. In some cases, planning grant recipients obtained technical assistance and consulting services from CHCS to help them develop their design and implementation plans.

Focus on Synergies. Another key change in strategy was the growing link between CHCS’ technical assistance activities and its grants program. The short-term evaluation conducted by MPR pointed to the need to develop a more integrated vision of how CHCS’ strategies relate to one another and where there are critical synergies. In particular, the authors noted the need to focus attention on the relationship between grants and direct hands-on work.

Since then, CHCS has moved from providing grants unrelated to technical assistance or BCAP activities (1995-1999) to linking grants and technical assistance work (2000-2004). Among the 12 organizations that have received model demonstration grants, 10 have been participants in a CHCS-sponsored technical assistance activity. Many of these grantees developed ideas for a planning or model demonstration grant as a result of participating in a Purchasing Institute or BCAP workshop. In other cases, CHCS encouraged grant applicants to participate in the Purchasing Institutes or BCAP as a way to prepare for a planning or model demonstration grant.

Starting in 2003, CHCS made the link more explicit by actively soliciting proposals from participants in its technical assistance programs. CHCS staff feel that with the expertise they have gained over the years, CHCS is now well positioned to approach the key players in Medicaid managed care about specific ideas and projects it is interested in funding.

Targeted Grant Making. Over the years CHCS has become more selective in the types of projects it funds. At the program's inception, CHCS based its grant making on a competency matrix it had developed that detailed the skills and expertise that states and health plans needed to develop to improve service delivery in their Medicaid managed care programs. The competencies included topics such as rate setting methodologies, purchasing strategies, and a focus on specific populations, such as the disabled and mothers and children.

CHCS' strategy initially was to fund promising projects in any competency area that focused on vulnerable populations identified by CHCS. Over time, however, CHCS began narrowing its focus to projects directed toward its three primary audiences. During that time, CHCS began soliciting best practices proposals that addressed these topics.

In 2000, CHCS further targeted its grants program by issuing a special, one-time solicitation inviting states to submit proposals to improve their community-based long-term care services. These were a specific type of best practices planning grant that CHCS funded as part of its new "Community Integration Initiative," which was tied to the U.S. Supreme Court's decision in the 1999 *Olmstead v. L.C.* case. CHCS saw the Supreme Court's ruling that states "must develop a comprehensive, effectively working plan to provide medically appropriate community-integrated care to eligible populations" as an opportunity to enhance the provision of managed long-term care. Under this initiative, CHCS awarded planning grants of \$100,000 each to seven states. Table 6 summarizes the results of projects conducted under the planning grant.

In 2002, CHCS began to target model demonstration grants to projects that address one of three areas: managed care for children with special needs, managed behavioral and general health coordination, and managed long-term care. While CHCS hesitated to tackle these difficult-to-serve populations in the past, Center staff now believe that they have enough experience and successes with other populations to make valuable contributions in these areas. In addition to the grants, CHCS is also trying to address these topics through some of its technical assistance activities.

At a CHCS board meeting in June 2003, the grant process became more restrictive in keeping with the strategic movement away from grant making and toward training and technical assistance. The upper bound on model demonstration grants was reduced from \$700,000 to \$250,000, unless the board gives its special approval. Indeed, very few grants will be awarded in the future that cost more than \$100,000. According to Center staff, grant making now is seen more as a training and technical assistance component than as a central function of CHCS. CHCS will fund no more than four to five unsolicited ad hoc grants per year.

Since 2002, the number of ad hoc grant proposals that CHCS has received and approved dropped dramatically. Between March 2002 and February 2003, CHCS accepted 19 of 168 grant proposals received, or 11 percent. Between March 2003 and February 2004, CHCS accepted 5

TABLE 6

DESCRIPTION OF PROJECTS CONDUCTED UNDER THE COMMUNITY
INTEGRATION INITIATIVE (OLMSTEAD) PLANNING GRANTS

State A	State A held six statewide focus groups with consumers and consumer advocates to determine the need for improved access to services, consumer choice and control, and resources for home and community-based services for elderly and disabled individuals. Results of the focus groups identified similar concerns across the state, including the need for ongoing consumer involvement, increased public awareness of available resources, and current and future state funding. In addition to CHCS funding, State A received a Ticket to Work Infrastructure grant and a Real Choice Systems Change grant from the Centers for Medicare and Medicaid to further the state's Olmstead planning efforts.
State B	State B now has a model action plan to move individuals into home and community-based care settings. The plan was developed by its Olmstead planning committee, which brought together consumer advocates, consumers, providers, and leaders of various state agencies. The resulting plan includes a number of recommendations that require no new funding. An executive order signed by the governor directs state agencies to collaborate to overcome barriers to community living, requires the appointment of a representative of the Children's Advocate Office and the Council on Aging to serve on the Olmstead Planning Commission, and establishes a state policy that children and adults with disabilities who could be served in the community need not be institutionalized to receive appropriate services. The committee has recommended that work on those activities begin immediately.
State C	State C developed several recommendations that have been passed on to the state for possible implementation to reach compliance with the <i>Olmstead</i> decision. Highlights of State C's grant work include building consensus on specific action steps among the various stakeholders to ensure successful community living, designing a single point of entry for beneficiaries, educating providers and consumers on the options for beneficiaries, increasing coordination among programs, and conducting better data collection and analysis. State C also has been able to allocate \$50 million for community living alternatives for people with developmental disabilities.
State D	State D gathered extensive input from consumers through focus groups, case studies, interviews, and consumer representatives on its Community Based Living Work Group. State D also developed the Roadmap for Community Based Living, which identifies a vision beyond the Olmstead requirements. In addition, State D established strategies for implementing and sustaining its efforts at interdepartmental collaboration and data integration. State D received a Real Choice Systems Change grant from the federal government to further its community-integrated health care services.
State E	State E has organized a Community Access Steering Committee (CASC) to oversee the state's Olmstead initiative. The state is working to design and evaluate an assessment tool to determine the types of supports or services individuals need as they move into the community.
State F	State F is developing a statewide plan to ensure the orderly transition of individuals who could be appropriately placed in the community. The governor has established a Home and Community-Based Services and Consumer-Directed Care Commission. As part of its task, the commission held six public hearings throughout the state. The most frequently raised issues included caregiver compensation; affordable, safe, and accessible housing; and informed choice.
State G	State G developed and implemented a program in which teams of medical personnel, social services workers, and consumer representatives helped residents of nursing homes make the transition back into their communities. The teams helped 30 long-term residents successfully make the move out of nursing homes.

of 76 grant proposals received, or 7 percent.²⁵ The downward trend indicates that CHCS' interest in grant making has cooled off, which potential grantees seem to understand (by submitting fewer proposals). Consistent with CHCS' new strategy, it has become more selective in the projects it is willing to fund.

CHCS henceforth will receive board approval for an overall strategic grant making plan before each fiscal year that will include monies for that year's targeted solicitations and ad hoc grants. For example, in fiscal year 2004, CHCS requested money for up to four grants (up to \$50,000 each) for a Clinical Pharmacy Management Initiative, up to five grants (up to \$100,000 each) for the Business Case for Quality, and up to three grants (up to \$75,000 each) for Managed Long-Term Care, as well as up to \$250,000 for one model demonstration grant, and up to four ad hoc grants (up to \$100,000 each).²⁶ Grants will continue to be reviewed by the National Advisory Committee (formerly the NRC).

The current plan highlights a major change in grant giving assumptions. Earlier, grants were designed to cover all or a substantial share of the costs of making a change. The current group of grants focus more on use of a small amount of funding that CHCS hopes, along with the prestige of the funder, will provide sufficient incentive for states and health plans to move forward. Obviously, for such a strategy to succeed, the deficit in funding will have to be made up by the grantee. Thus, providing a "business case" for such investment becomes increasingly relevant.

2. The Business Case for Quality in Medicaid

In November 2003, CHCS issued a call for proposals on the Business Case for Quality (BCQ) in Medicaid, in response to a *Health Affairs* article that failed to mention the potential to save money on Medicaid quality initiatives. The BCQ seeks to demonstrate and evaluate the ability of Medicaid stakeholders to invest in quality-enhancing initiatives to improve care for beneficiaries with chronic illnesses. CHCS views the BCQ initiative, funded by the Commonwealth Fund and supplemented with MMCP money, as hugely important to its mission.²⁷ In the future, CHCS plans to follow a similar template as the BCQ for its grant making activities, namely restricting its solicitations to ones that use a targeted approach and can be highly leveraged.

Of the 24 proposals received for the BCQ, CHCS selected 10 grantees, which will receive up to \$50,000 each. The grants will run from June 2004 through June 2006. The Commonwealth Foundation contracted directly with the University of North Carolina's School of Public Health to evaluate the success of the 10 grantees on multiple levels:

²⁵ These figures do not include targeted solicitations, e.g., the Business Case for Quality in Medicaid and Health Disparities.

²⁶ The solicitation on the Business Case for Quality was amended to be 10 grants at up to \$50,000 each. The third solicitation (on Managed Long-Term Care) may be postponed until FY 2005.

²⁷ The Commonwealth Fund has contributed \$394,000 to the independent evaluation of the BCQ, and the MMCP will contribute approximately \$700,000 to the overall project.

1. Business Case: Return on investment for participating organization, health plan, state program, medical group, hospital, etc.,
2. Economic Case: Projected economic benefits of the quality-enhancing initiatives to payers (e.g., other plans, the state purchaser, etc.), including both financial and administrative savings, and
3. Social Case: Imputed value of expected improvements in the quality of life and satisfaction of beneficiaries, their increased productivity, and corollary reductions in need for other publicly financed social services.

The evaluation is scheduled to be completed in May 2007 and represents one way that CHCS can determine the value of its targeted solicitations. Center staff say they will use this evaluation as a model for evaluating the success of future solicitations.

B. PUBLICATION AND COMMUNICATIONS

Publication and dissemination are core functions of the MMCP and are relevant across many of CHCS' individual initiatives. These functions provide a vehicle for leveraging some of the outputs from grants and other activities to reach a broader constituency. CHCS continues to enhance publication, dissemination, and marketing operations, with the current work reflecting the agenda set by its former communications director, Seth Klukoff, who assumed his post in January 2000 and resigned in October 2004. At that time, communications shifted to a more strategic focus, targeting the organizing principles that guide CHCS' programs and activities: (1) informed purchasing, (2) managed care best practices, and (3) consumer action.²⁸ Rather than release all of its materials as reports, CHCS created three tiers of publications: (1) Eight to ten-page reports of seminal work, (2) longer working papers, and (3) focused synthesis products such as toolkits, best practices, and issue briefs. CHCS aims for a six- to eight-week turnaround from submission to decision and publication. Dissemination focuses on a core mailing list that contains names of diverse audiences. In addition, all publications can be downloaded from the Internet.

MPR's assessment highlighted the continuing challenges that CHCS faces in making publications available and useful. Probably the foremost challenge stemmed from the breadth of CHCS' substantive focus and the diversity of its core audiences. Not all individuals are interested in the same publications, and those who are interested in the materials may have different interest levels in terms of detail and focus. The authors noted that while organizing publications around CHCS' substantive goals made sense, CHCS needed to undertake additional work to more fully identify the core audiences for diverse publications, what is needed to reach these audiences most effectively, and which forms of translation or dissemination are highest priority. The assessment also indicated that CHCS could benefit by thinking about how it might best use electronic technology to help its core audiences retrieve information they need when they need it. For example, they could disseminate not only formal reports but also documents

²⁸ At the time, the Center had four organizing principles, but the fourth principle, "Integrated Systems of Care," has since been incorporated into the remaining three.

developed for the Purchasing Institute, Pricing Forum, BCAP workgroups, and Consumer Action Agenda. Such efforts, the authors noted, would help institutionalize the “memory” of state experience and make CHCS more of a living repository of information on what states, plans, and consumers are learning about how best to structure and operate Medicaid managed care.

Since the assessment, CHCS has worked on establishing itself as the “go-to” operational resource for states, health plans, and consumer organizations committed to improving the quality of care in Medicaid and SCHIP. It has placed substantial emphasis on electronic communications—in particular, its Web site and e-newsletters targeted to its core constituents—as a primary dissemination medium. CHCS developed four e-newsletters: one focusing on general topics and three on segmented topics corresponding to the organizing principles; it maintains a separate distribution list for each e-newsletter. CHCS also implemented a Communications Technical Assistance Program to help participants in CHCS’ major initiatives develop communication strategies. CHCS said that communications issues are identified and technical assistance is provided on an as-needed basis. In 2001, a new Web site was launched, and CHCS established a graphic identity and logo.

In 2002, a major communication goal promoted the importance of “collaboration for quality.” To this end, CHCS expanded the focus of its briefs to include Center projects that illustrate successful collaboration among its core audiences. CHCS also created a bimonthly Web site feature, “Focus on Collaboration,” which showcased projects that demonstrate how states, plans, and consumer groups work together to improve quality. Since that time, the feature has given way to a monthly Project Spotlight that highlights success stories that have emerged from participant’s work with CHCS.

In late 2003, CHCS started to develop a new communications strategy. Until then, the objective had been for CHCS to build its identity, which focused on CHCS’ three key stakeholder groups. Communications were segmented narrowly based on stakeholders such as the informed purchasing series. CHCS’ new objectives have expanded to position CHCS as a national quality improvement leader in publicly financed care, demonstrating that quality pays in Medicaid (and not just Medicaid managed care). The new communications strategy grabs hold of this new objective through a two-phase implementation process. Phase one, lasting from March 2004 to June 2005, involves what CHCS staff view as “burnishing the base and expanding the message.” CHCS will continue to place heavy emphasis on promoting its two signature products—the BCAP and Purchasing Institute. At the same time, CHCS will begin to reach out more frequently to national audiences such as other health care quality improvement groups (e.g., ICIC, IHI, NICHQ), current funders, national associations (e.g., National Conference of State Legislators, National Governors Association, National Association of State Medicaid Directors, American Association of Health Plans), federal agencies (e.g., Centers for Medicare & Medicaid Services, Agency for Healthcare Research and Quality, HRSA), and the national media. CHCS plans to identify more opportunities to communicate the outcomes of its work, and to focus on shorter briefs and toolkits. CHCS plans to adopt a tone that is more assertive and far-reaching than its traditional “neutral arbiter” stance.

During phase two of the implementation process, from June 2005 to December 2006, CHCS will attempt to solidify itself as a leader in quality improvement and “move the market.” Building on phase one activities, it plans to form “cadres” of Medicaid managed care spokespersons from its pool of stakeholders who, on behalf of CHCS, can spread a quality

improvement message nationally. The ultimate goal of this phase would be for CHCS to strongly move the publicly financed health system (in particular, Medicaid) toward achieving tangible, lasting improved outcomes.

CHCS staff say they initiated the first phase of its new strategy when it re-launched its Web site in March 2004 to match its evolving identity. The new Web site, they believe, is easier to navigate and search, and it contains an extranet for use by those involved in CHCS projects. In recent years, the Web site has averaged 4.8 million hits per year and 250,000 unique users per year; these users have visited a wide range of the site's areas. As part of this phase, CHCS also consolidated its four electronic newsletters into one, which links directly to the Web site for more detailed descriptions.

CHCS has implemented two other major communications initiatives to capitalize on its ability to bring together stakeholders to discuss emerging trends. First, in 2003, CHCS established the BCAP Network Exchange Calls as a forum to discuss issues in quality improvement and to share best practices among participants. At times, CHCS also has used the activity to advance its strategic objectives by sponsoring calls on topics that it views as important, such as Return on Investment. Currently, CHCS runs a parallel structure between calls with health plan staff and calls with state Medicaid staff. Most resources for this activity have been devoted to sessions with health plans. More recently, 90-minute teleconferences have been offered bimonthly for states and plans, featuring CHCS experts and guest presenters and allowing time for questions and feedback from participants. The Network Exchange Calls have included topics, such as predictive modeling, evidence-based practices in children's behavioral health, the clinical pharmacy management initiative, and performance-based auto-assignment.

Second, CHCS created a listserv for health plans as means of electronically linking stakeholders to one another and facilitating sharing of information. The BCAP Network Listserv, which currently includes 338 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 how to find sources of technical information. The listserv averages about 15 hits per month. During MPR's communication with BCAP participants, health plan staff noted the usefulness of the listserv and felt that CHCS had developed a sense of community through the 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.

C. MISCELLANEOUS ACTIVITIES

MPR's short-term assessment suggested that CHCS develop a more integrated vision of how the different stakeholders relate to one another and identify areas with critical synergies. CHCS has tried to address these issues partly by offering activities that incorporate multiple constituent groups. In addition to the multi-constituent activities that have already been described, such as the Asthma Collaboratives and disparities initiative, CHCS also has tried to package its older activity, such as the Managed Care Solutions Forum (previously the Pricing Forum), so that it fits its new strategic organization. CHCS also has opportunistically sought out other projects that offer new ways for CHCS to share its expertise through training and technical assistance

initiatives. These projects, such as the AHRQ User Liaison Series, reflect CHCS' attempts to branch out strategically in ways it says allow it to pursue its operational goal of improving quality in Medicaid managed care through training and technical assistance. Diversifying the funding base obviously is also an important other core goal of such activities and they are likely to grow in the future.

1. Managed Care Solutions Forum

The Managed Care Solutions Forum aims to “improve publicly financed managed care programs by formulating operational strategies for solving salient problems.” Through national meetings and funded policy studies, the Forum’s ultimate goal is to foster better business relationships among states, health plans, and consumers so that they can develop cohesive, collaborative, and sound management practices. The Forum was designed to meet approximately once a year and bring together representatives from the Centers for Medicare & Medicaid Services (CMS), health financing experts, state administrators, health services researchers, and health plan executives.

Formerly the Managed Care Pricing Forum, the Solutions Forum initially focused on the technical and diplomatic challenges involved in pricing publicly financed managed care. Under the Pricing Forum, CHCS convened two meetings in November 1999 and September 2000 that focused on case mix changes, rate setting, the upper payment limit, and the Balanced Budget Act of 1997. As the Managed Care Pricing Forum developed, CHCS broadened its scope to explore operationally and politically feasible solutions that address the growth in health expenditures and renamed it the Managed Care Solutions Forum.

MPR’s 2001 assessment highlighted two issues for further consideration. First, it would be advisable to reassess the Forum’s core strategy and mission in order to address more fully member questions about strategic objectives while ensuring that these questions do not ultimately detract from the broad-based support and participation that makes the Forum valuable. Second, it also would be advisable to strengthen the Forum’s administration by meeting more frequently and on a predictable schedule, increasing communication between meetings, and clarifying processes for setting priorities.

The focus of the second Solutions Forum shifted to medical management strategies, such as physician profiling, disease management, and the use of pharmacy benefit managers. In June 2002, CHCS convened a Forum on pharmacy and medical management in Medicaid and SCHIP managed care to develop a technical assistance strategy to help states and health plans build cost-effective, quality-driven pharmacy and medical management programs.

CHCS has not held a Solutions Forum since 2002. In the future, Center staff say that the Forums will focus on issues deemed to be of interest, such as disease management for behavioral health. That is, CHCS is maintaining the Solutions Forum as an ad hoc infrastructure that it can use when needed.

2. Federal Funding

CHCS made its first foray into government contracting with its project, AHRQ User Liaison Series. CHCS is a subcontractor to the Lewin Group; the prime client is AHRQ. The project, valued at \$426,387, began in February 2004 and ends December 2009. CHCS is assisting with the design of knowledge diffusion activities in the area of state Medicaid purchasing. CHCS will offer direct technical assistance to participants in Lewin training activities, including content expertise on purchasing issues and on rapid cycle improvement/measurement techniques. Government contracting represents a potential growth area for CHCS. In addition, this activity closely adheres to CHCS' stated strategy of pushing for quality improvement through training and technical assistance and may be representative of the type of new initiatives that CHCS will explore in the future.

V. CONCLUSION

The Center for Health Care Strategies has evolved substantially since its inception in 1995. The organization initially was established as a program office to administer grants for the MMCP. Today, CHCS offers a bevy of initiatives that seek to assist its three main audiences to become more prudent purchasers of Medicaid services and improve the quality of health services provided to Medicaid managed care beneficiaries.

CHCS' strategic focus has changed course several times over the years, leading to its current position. The most important change was the reorganization of CHCS around its four, now three, organizing principles. By identifying these main principles and their corresponding audiences, CHCS was able to design and tailor activities aimed at these groups. As a result, the core initiatives were developed: the Purchasing Institute for state Medicaid staff, the BCAP initiative for health plan administrators, and the Consumer Action Agenda for consumer-based organizations. These initiatives paved the way for subsequent activities that have helped the program try to accomplish its mission. CHCS has decided that its objectives can best be met by working directly with its stakeholders, and CHCS believes that it can most effectively work with these groups through more training and technical assistance activities, which CHCS staff view as a core competency.

With RWJF's support, CHCS has grown rapidly in terms of staff, functional responsibilities, and ongoing initiatives; however, CHCS has grown beyond the confines of the Medicaid Managed Care Program. Many important Center activities funded today are either solely or jointly financed with non-MMCP funds. CHCS now sees the MMCP as only one part of its operations, albeit a large part. Diversified funding has given CHCS more flexibility and stability in the types of activities it can sponsor, and diversification has the potential to lessen CHCS' dependence on one funding source. CHCS, however, still depends heavily on RWJF for support at this stage.

Constantly changing priorities in the health care marketplace complicate the mission of CHCS. CHCS staff have been serious in thinking about strategy in a fluid environment. They have emphasized the flexibility of their operations to fit this moving target. But there remains a challenge for CHCS to balance a focus on long-term commitment—which is necessary for widespread, sustainable change—with flexibility to adapt to circumstances. Going forward, CHCS must consider how flexible its strategy should be in order to realize short-term gains versus holding its course and keeping its sight on long-term goals.

CHCS' MMCP has become well established and positioned itself to gain the support of a diversity of funders. Core MMCP activities have provided support that has been very important in getting CHCS to its current position, and MMCP funds continue to provide the “investment capital” that has helped CHCS pursue new initiatives. Many core issues remain fundamental for the future, however. In particular, while substantially more focused than previously, CHCS continues to have broad ambitions, and achieving success with all of them may be hard. For example, right now CHCS' work with consumers is little more than token, and there is still much work to be done in developing solid measurements to guide its quality improvement activities. With resources limited, each activity that is undertaken means that trade-offs are inherently being

made. For example, CHCS has been able to gain time for its work on MMCP with existing funds, but the extension has limited the amount of resources available for work in any given year and affected most of its capacity to give grants. While CHCS believes this is an appropriate trade-off, there remain opportunity costs. Similarly, work on general quality improvement has led to less exclusive emphasis on targeted work for Medicaid beneficiaries with very complex and special needs. Each of these trade-offs involves tensions and value judgments on how best to proceed. In addition, whether CHCS' assumption that its work on Medicaid managed care can be translated elsewhere, particularly to other payers that function in very different environments, is mainly untested at this point. As RWJF considers the results of the renewal of MMCP in the context of CHCS, it will want to consider how it views these priorities and how the findings from the evaluation can shed light on what the trade-offs and their implications may be.