A "BEST PRACTICES" STRATEGY TO IMPROVE QUALITY IN MEDICAID MANAGED CARE PLANS

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ABSTRACT Medicaid managed care is delivered through organizations operating in very heterogeneous environments that confront similar barriers to success. Because Medicaid managed care is implemented differently in each state, health plans have been isolated from each other and have not had an opportunity to learn how others may have surmounted commonly encountered barriers. After interviewing Medicaid health plan medical directors, we developed a learning collaborative model based on shared categories of problems they would need to address before they could implement a successful improvement strategy in an important clinical area, birth outcome improvement. Under the Best Clinical and Administrative Practices initiative, we have brought together 12 Medicaid health plans to work together on strategies and specific objectives for overcoming obstacles to improvement. Evaluations by participants have been positive, and they appear to be making a number of specific organizational changes based on learning from the collaboratives. We will be employing this organizational development model to a series of clinically and administratively important topics over the next few years.

INTRODUCTION

Medicaid health plans cover the health care of America's low-income and disabled populations and operate in individual state and regional markets that are regulated heavily and heterogeneously. Unlike the Medicare program, for which a national purchasing standard exists, or commercial health insurance, for which many organizational policies and procedures can assume a baseline level of member resources, Medicaid managed care is delivered by organizations that confront similar intractable problems within very different regulatory environ-

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ments. As a result, it is difficult for Medicaid plans to share their experiences in addressing the needs of their membership. They do not share an effective national forum for discussing issues, even as they face common problems of poverty, cultural difference, and homelessness and a heavy burden of incurable chronic illness.

Medicaid plans experience considerably higher population turnover than do commercial or Medicare plans. The "churning effect" is considerable nationwide, with Medicaid plans experiencing disenrollments of 10–15% each month.[1] Further, the membership is far less likely than are commercial or Medicare populations to have stable housing, a reliable mailing address, a telephone, or a continuous long-term relationship with a specific health care provider. As a result, many well-designed programs that have been successful in other managed care settings have failed in the Medicaid environment over such basic issues as identifying people with defined health care problems in a timely way (given ongoing population shift) or finding members to offer specified health interventions (given the high frequency of unreliable address or telephone member demographic data). The impact of health improvement programs often turns on the success or failure of baseline activities that are not even thought to be problematic in other managed care environments.

As it turns out, different organizations have "solved" some of these problems in their own settings, often utilizing creative strategies of community partnership or organizational process re-engineering. A Medicaid plan that added, "If you're pregnant, press 6," was able to improve significantly the number of women in their population identified as being pregnant. These kinds of "on-the-ground" solutions typically are not published or disseminated widely.

Based on a series of interviews with chief medical officers and senior quality management staff at 24 health plans around the country that cover the Medicaid population, either as their only activity or as one of several lines of business, we identified commonly experienced barriers to success, as well as examples of strategies for addressing them. We recognized a pattern in the kinds of barriers and created a classification system, or "typology," meant to structure conversations among diverse plans. We convened a work group in a learning collaborative format to share experiences of success and of barriers using the typology format to organize their conversations.

In this paper, we summarize our work group experience to date and discuss relevant issues in Medicaid managed care that have been important to the future success of the work group.

BEST CLINICAL AND ADMINISTRATIVE PRACTICES

The Medicaid Managed Care Program (MMCP) developed its Best Clinical and Administrative Practices (BCAP) project to facilitate the sharing of managed care practices by Medicaid and State Child Health Insurance Program (SCHIP, a federally funded health program for children that was implemented in 1998 under the 1997 Balanced Budget Act) plans, which promoted improved management of member care, improvements in quality of care, and a return on investment. The unmet need of Medicaid health plans to share best clinical and administrative practices has been readily apparent in work commissioned by the MMCP, a national program of the Robert Wood Johnson Foundation directed by the Center for Health Care Strategies (CHCS).

Since 1995, MMCP has worked closely with state Medicaid purchasers and Medicaid plans to build capacity to serve low-income, high-risk and chronically ill enrollees. In a recent synthesis of MMCP grant making, significant trends emerged for Medicaid plans, including

- Commercial health plans serving Medicaid members are exiting the Medicaid market,[2] while safety net providers are entering Medicaid managed care as new health plan players.[3]
- Prudent purchasers (such as state Medicaid agencies) are placing greater emphasis on measuring quality and consumer satisfaction.
- Declining Medicaid rolls resulting from welfare reform may be leading to a sicker population remaining in Medicaid plans.[4]

In response to these trends and to the heterogeneous nature of the Medicaid and SCHIP regulatory environments in which plans operate, MMCP launched the BCAP project in April 2000 with 11 health plans from around the country. These plans represent a cross section of the Medicaid managed care industry (commercial plans with Medicaid product lines, Medicaid-only plans, large and small plans, network and Independent Physician Association [IPA] model plans, geographic diversity) and cover roughly 1.3 million recipients of the total 35 million individuals on Medicaid today.

The overall mission of BCAP is to improve the quality of health care for the nation's low-income, high-risk, and chronically ill populations by promoting practices that address the clinical and administrative challenges facing plans contracting with Medicaid and SCHIP agencies. While existing disease management and quality improvement training programs available to all health plans focus on providers or are driven by reporting requirements, Medicaid plans face unique challenges that call for a different approach. BCAP offers a strategic

TABLE I Medicaid Challenges and the Best Clinical and Administrative Practices (BCAP) Response

Medicaid Challenges	BCAP Response
1. Medicaid members enter care sicker and more frequently than do commercial members.	1. Plans and their providers will be encouraged to consider low-cost, creative outreach strategies to get members into care before health conditions become present or are exacerbated.
2. Medicaid members have fewer community supports (e.g., transportation, telephones) to maintain dependable health outcomes.	2. Plans will consider both community-based and plan-supported outreach programs as a routine part of their BCAP design.
3. Medicaid members, unlike commercial members, do not bear financial consequences from failure to follow administratively prescribed policies and procedures.	3. Plans will consider strategies that motivate members to comply with medical recommendations.
4. Medicaid plans experience high member turnover and may hesitate to invest in improvement projects that do not realize immediate results.	4. BCAP will focus on topics that can realize immediate results in health outcomes and cost savings or that are deemed a priority by their state or the federal government.
5. Medicaid plans are fundamentally administrative organizations that employ population-based rather than patient-based methods to improve health outcomes.	5. Plans will address planwide, operational systems that support their mission to manage the health care needs of vulnerable populations on Medicaid.
6. Medicaid plans operate in heavily and diversely regulated environments that must figure prominently in improvement methods.	6. BCAP will link to state and federal requirements to comply with NCQA, HEDIS, and QISMC expectations for quality management and improvement.
7. Medicaid plans have much thinner margins for innovation than commercial plans. This jeopardizes the sustainability of all research and development endeavors.	7. As stated in item 4, BCAPs will focus on topics that can bring immediate results in health outcomes and cost savings or that are deemed a priority by their state or the federal government.

response to the challenges of serving Medicaid and SCHIP beneficiaries (see Table I).

MEDICAID PLAN MEDICAL DIRECTOR SURVEYS

CHCS conducted a series of telephone interviews with plan leaders in spring 1999 to learn about Medicaid plan priorities and barriers in improving birth outcomes. There were 24 interviews conducted with the medical directors and quality improvement directors of 12 health plans that provide service to Medicaid beneficiaries in 10 states. The interview sought to identify existing "best practices," assess perceived needs for improvement in certain clinical or administrative topic areas, identify potential faculty for the BCAP project, and gauge the level of interest in and possible barriers to participation in the proposed BCAP project. Each interview was approximately 1 hour in length. The number of interviews was too small to present a meaningful quantitative analysis of the

results, but several general themes emerged. This analysis focuses only on the medical director interviews.

The majority (7 of 12) of medical directors were unable to cite their single program that "added the most value for Medicaid beneficiaries." In plans that managed both commercial and Medicaid product lines, virtually all medical directors noted areas in which they had achieved significant improvement in the commercial (and, in some cases, Medicare) population, but they had not been able to extend those results or programs to the Medicaid population. Several medical directors reported that they either were rolling out or had in place programs they believed would be promising, but they did not yet have data to support that belief. Only one medical director claimed "success," but the example seemed to be based on deeply flawed data and measures. Other medical directors were more aware of the problems they had documenting success. Three plans claiming successes cited their activities in medical informatics, discussing either structural approaches (e.g., having created a separate department or division of medical informatics) or particular approaches (shared data definitions across the company, "data-mining" techniques to extract meaningful information from a welter of data). The importance of data strategies should not be underestimated because the most common problem mentioned by those who were unable to cite successes was the inability to identify relevant populations.

Common health plan programs addressed asthma, high-risk pregnancy, immunizations, and behavioral health. The health plan of virtually every medical director interviewed either offered programs in these areas or was in the process of developing them. Centralized case management was a frequent strategy for implementing the programs, both in house and outsourced. The choice of focus was driven by existing commercial activities of the plans, state regulation, and National Committee for Quality Assurance (NCQA) expectations, as well as by the limitations and opportunities created by the data system. Other programs included those for human immunodeficiency virus (HIV) (none mature, all under development), pharmacy, and end-of-life care (not exclusively for Medicaid enrollees). There were occasional nascent efforts at statewide collaborations in data collection, such as for the Early and Periodic Screening Detection and Treatment (EPSDT, a comprehensive, preventive health program for Medicaid eligible individuals under age 21) program and high-risk pregnancy, with a focus on developing standardized approaches and constructing central registries.

Major barriers to success cited by plan medical directors included an inability to obtain relevant data, population turnover (one plan reported 15% per month), fragmented marketplaces and delivery systems, staff turnover, absence of identifi-

able performance benchmarks, and difficulty contacting members (inability to reach 40–50% of membership by telephone).

Almost all of the interviewees expressed interest in participating in a national collaborative effort focused on improving clinical and administrative practices. Opportunities they perceived from the proposed BCAP effort included identifying and working with a peer group, being able to develop and acquire benchmarks, and collaborating in a focused way to achieve improvement. CHCS has incorporated process improvement and organizational change methods into BCAP to address plan priorities for tracking and demonstrating improvements.

The biggest concern of the plans about participation in such an effort was the risk of it being a waste of time. Though the interviewees cited issues of local competitiveness as obstacles to successful collaboration in their individual marketplaces, none of them expected such a problem in a national collaboration, and all of them denied that it would be a barrier to their own participation.

FORECASTING MEDICAID MANAGED CARE PLAN PRIORITIES

Based on the interviews and our knowledge of the marketplace, we can predict several priorities of Medicaid plans over the next few years. Our knowledge is drawn from the last 5 years of grant monitoring and technical assistance work under MMCP with state Medicaid agencies and Medicaid health plans. The BCAP project will respond to the concerns stated by Medicaid health plan representatives. A major focus will be meeting the needs of special populations—specifically children with special needs (e.g., children with physical or developmental disabilities), people living with HIV/AIDS (acquired immunodeficiency syndrome), and disabled populations who qualify for Medicaid coverage under the Supplemental Security Income (SSI) category of assistance. The challenges are likely to be enormous and will be driven by organizational needs to link these members with an array of social services. The need of Medicaid beneficiaries for ancillary and social support services, including housing, child care, and transportation, and the consequence of missing these key elements in an overall package of care will force Medicaid plans to develop medical programs that coordinate with community-based organizations that address nonmedical needs. There are also trends toward carve-outs in managed care programs, as when particular services (e.g., behavioral health care) or populations (e.g., people diagnosed with AIDS) are paid for and managed by a specialty contractor apart from the standard benefit package handled by the Medicaid plan. Carve-out arrangements can contribute to barriers for integrated service delivery. Therefore, Medicaid plans increasingly will need to build successful relationships with

organizations that provide these additional services (e.g., social case management). Plans will also experience an increase in the volume and dollar levels of medical claims as they attempt to incorporate special populations.

GATHERING, PILOTING, DOCUMENTING, AND DISSEMINATING BEST PRACTICES

Through BCAP, CHCS is convening chief medical officers of up to 60 Medicaid plans to gather, pilot, document, and disseminate best practices. Our assumption has been that there is not a single best practice for Medicaid plans. As the BCAP project proceeds, in fact, some have challenged our use of the term *best practice.* Indeed, individual plans are identifying and developing a number of practices that work well for them, but that may not transfer easily to another plan. Plans may identify several practices to address one health care barrier and may employ a few or all of these at the same time. What works best is a relative term.

To develop best practices for targeted clinical and administrative areas, we developed a classification system of steps that address the barriers that Medicaid plans face in serving their membership. The steps organize operational strategies culled from Medicaid health plans to model a comprehensive program. For example, in the first BCAP work group, we created a five-part initiative for improving birth outcomes (see Table II).

This classification system will change for each BCAP topic addressed by future work groups (e.g., the Improving Preventive Care Services for Children BCAP work group is adding an additional step to their classification system, focus, which refers to the prevention services that the respective health plans will treat as priorities under BCAP).

TABLE II Steps for Improving Birth Outcomes

Steps in Process	Description of Step Components
Identification	Methods for finding pregnant members
Stratification	Methods for screening pregnant members by their health risk(s) and associated levels of severity
Outreach	Plan activities to seek out pregnant members, to bring services to them when they do not seek care, and to encourage prevention
Intervention	Plan program activities that respond to member risk factors (e.g., smoking cessation, nutritional counseling, transportation)
Measurement	Defined activities to track proximal and distal process improvements and health outcomes that enable corrective action by plans in program design

Source: MMCP BCAP Workgroup on Improving Birth Outcomes, April 2000.

Under the improving birth outcomes classification, *identification* involves finding out who is pregnant, for instance, Does the plan have a mechanism in place for identifying pregnant health plan members? Can it be improved? If plans do not have successful programs for identifying pregnant plan members, they will not be able to achieve success in improving birth outcomes.

Similarly, *stratification* involves knowing what risk factors patients actually have. If plans do not have high-quality clinical information, they will not be able to create targeted programs to meet the needs of patients. One BCAP participant, the Neighborhood Health Plan in Boston, Massachusetts, in cooperation with the Medicaid Working Group, a technical assistance center at the Boston University School of Public Health, recently surveyed 56 Medicaid plans serving SSI enrollees and determined that 50% of plans conduct health risk assessments of new members and existing members, a simple stratification activity that few plans performed just 5 years ago.

Outreach brings health care to pregnant members who have not presented for prenatal care, such as sending a home health nurse to the homes of members in the second trimester who have been identified as pregnant, but who have not kept prenatal appointments. During outreach, the home health nurse performs a prenatal exam, may schedule another office-based exam, and may assist with transportation planning.

Intervention steps include health programs that respond to common problems during pregnancy (e.g., counseling for smoking cessation). *Measurement* enables Medicaid plans to track short- and long-term outcomes associated with the previous steps, such as tracking the proportion of Medicaid members who deliver over 12 months who presented for prenatal care prior to and after BCAP (short term) and comparing the average birth weight of the same population's newborns (long term).

PRELIMINARY SUCCESS

Gathering chief medical officers and leading a discussion via the BCAP steps show early signs of success. The chief medical officers who participated in the first Improving Birth Outcomes BCAP meeting (April 2000) described their own plan activities within the classification steps and were able to learn different strategies from each other. We are hopeful that plans ultimately will emulate each other's best practices and educate each other about removing barriers to success. This is already beginning to happen within the Improving Birth Outcomes work group. For example, one BCAP participant, Arizona Physicians IPA, shared an identification strategy in which their main voice mail invites anyone

who is pregnant to "Press 6," and the call is routed directly to the Maternity Case Management Department. Through this simple intervention, this plan was able to increase its ability to identify pregnant women and thus conduct a targeted outreach. Three other BCAP participants have added this feature to their voice mail system.

When the Improving Birth Outcomes work group met for a second time in July 2000, it developed a set of universal outcome measures for identification, stratification, outreach, and global BCAP outcomes by which the progress of the health plans will be tracked.

The following are identification measures:

- Identification rate = Number of women known by the health plan to be pregnant prior to delivery divided by the number of deliveries in the health plan
- Identification by trimester = HEDIS measure: Trimester of entry into care (each of these measures is reported separately for (1) new enrollees and (2) existing members)

The following are stratification measures:

- Health Risk Assessment rate = Number with completed Health Risk Assessment divided by the number of women identified as pregnant

For outreach measures, contact percentage is the number of contacts made (individual contact) divided by the number of contacts attempted (i.e., needs to talk or hear back from an individual, not just send a form letter).

The following are the global BCAP outcome measures:

- Birth weight is taken from birth certificates: low birth weight (<2500 g) rate, very low birth weight (<1500 g) rate
- Gestational age is taken from birth certificates
- Neonatal intensive care unit days/1000 deliveries
- Neonatal intensive care unit admissions/1000 deliveries
- Maternity bed days/1000 deliveries
- Number of prenatal visits (HEDIS measure) (average per delivery)
- Rate of postpartum visits (number of postpartum visits/number of deliveries)

BEST CLINICAL AND ADMINISTRATIVE PRACTICES APPLICABILITY TO PRIMARY CARE CASE MANAGEMENT

Health plans are not the only organizations developing managed care best practices for Medicaid enrollees. A growing number of state Medicaid agencies are

launching or retooling their primary care case management (PCCM) programs and moving away from what had formerly been described as "managed care lite"* because of their limited use of managed care strategies and preservation of fee-for-service arrangements with monthly administrative payments (e.g., $2 per member per month to handle gatekeeping responsibilities). This new breed of PCCM, a response, in part, to the recent marketplace exit of many Medicaid plans as managed care contractors, closely resembles health plans in their use of primary care provider networks and reliance on those networks to assume both medical and administrative responsibilities.† The state of Arkansas manages a Medicaid PCCM program for all Medicaid beneficiaries and does not contract with health plans. Under this managed care program, Arkansas has joined the Improving Birth Outcomes BCAP work group.

The challenges of PCCM programs parallel those of Medicaid plans. Smith et al.[5] identified exemplary practices within PCCM programs and classified them as follows: management and organization structures, reimbursement methods, enrollment policies and methods, member services and education, provider recruitment and retention, quality improvement and utilization management, coordination with behavioral health, adaptation of the PCCM for special needs populations. As more and more PCCM programs come to resemble plans, the pool of organizations that can collaborate to find and expand best practices will grow.

CONCLUSION

For practical purposes, Medicaid plans associated with BCAP are piloting innovations and are collaborating to document and measure their initiatives to further clinical and administrative quality improvements for all Medicaid plans and their state Medicaid agency partners. The focus on best practices has offered plan leaders a vehicle to invest in what works in addition to troubleshooting what does not work.

CHCS will publish the products of each BCAP work group in a tool kit for other Medicaid plans, as well as for plans with SCHIP enrollees and PCCM programs. Each BCAP plan is customizing its steps (e.g., for improving birth outcomes), and affinity groups of like actions are evident. Common steps with demonstrated success will be catalogued in the tool kit to facilitate learning sessions with other Medicaid plans. BCAP work group members will serve as

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*B. Bullen, unpublished Medicaid Managed Care Program memorandum to the National Review Committee, September 1998.

†S. Rosenbaum, C. Sonosky, and A. Stewart, unpublished grant progress report to the Medicaid Managed Care Program, Nationwide Study of Contracts Between Medicaid Agencies and Primary Care Case Management Providers, April 2000.

faculty in a training effort. In addition to the Improving Birth Outcomes work group, future BCAP work groups will focus on best practices for improving pediatric preventive care services, improving pediatric asthma care, and improving care coordination for people with special health care needs. Additional topics will be selected in 2001. CHCS will also establish a permanent forum for Medicaid and SCHIP health plans that participate in BCAP to continue in the sharing and piloting of best clinical and administrative practices.

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