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Quality Management Strategies in Medicaid Managed Care: Perspectives From Medicaid, Plans, and Providers

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Abstract

Medicaid managed care allows Medicaid beneficiaries to receive services through contractual relationships between managed care organizations and state Medicaid offices. Medicaid offices monitor quality of care, and many states encourage or require plans to adopt quality management practices. This research examines quality management in Medicaid managed care from the perspectives of Medicaid officials, managed care plan representatives, and providers through 25 qualitative interviews in one Northeastern state. Plan representatives described quality management efforts as robust and discussed strategies targeting providers and beneficiaries. Medicaid officials indicated motivations for plans to be responsible for quality management. Providers were unaware of plan efforts or reported them to be counterproductive since performance data were thought to be inaccurate or limited, and modest incentive programs presented excessive administrative burden. Providers' general skepticism about managed care plans' quality improvement efforts may hinder their effectiveness, cause frustration, and lead to administrative burden that may harm care quality.

Keywords

qualitative; Medicaid; managed care; care management

Introduction

Under Medicaid managed care, private health insurance plans receive capitated payments from state Medicaid programs to finance health services for Medicaid beneficiaries. Medicaid managed care is on the rise, with more than 65 million Americans (81% of all

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Supplemental Material

Supplemental material for this article is available online.

Medicaid beneficiaries) enrolled nationwide (Kaiser Family Foundation, 2016b). The majority of these beneficiaries (approximately 55 million) are enrolled in risk-based managed care plans (Kaiser Family Foundation, 2016a). Approximately 93% of children enrolled in Medicaid are in managed care plans (Medicaid and CHIP Payment and Access Commission, 2016). State Medicaid offices that contract with managed care plans are responsible for monitoring the quality of care and outcomes of Medicaid beneficiaries enrolled in these plans, and many states either encourage or require managed care organizations to participate and invest in quality improvement or management (Centers for Medicare & Medicaid Services, n.d.). Such quality management strategies must include, at a minimum, regular assessment of care quality. This assessment often includes the Healthcare Effectiveness Data and Information Set (HEDIS) indicators, quality indicators that measure aspects of health and health care utilization including cancer screening, medication management, weight/body mass index assessment, immunization status, and asthma medication use (National Committee for Quality Assurance, n.d.). Little is known, however, about how plans structure quality management efforts, how they are perceived by providers and policy-makers, and whether these individuals consider that such efforts result in improved quality of care for Medicaid beneficiaries.

Research from the late 1990s and early 2000s has qualitatively examined managed care efforts to promote quality for Medicaid patients enrolled in managed care plans (Becher, Halm, Lieberman, & Chassin, 2000; Cukor, Fairbrother, Tassi, Butts, & Friedman, 2002; Fairbrother, Friedman, Butts, Cukor, & Tassi, 2000; Landon, Schneider, Tobias, & Epstein, 2004; Landon, Tobias, & Epstein, 1998; Schneider, Landon, Tobias, & Epstein, 2004; Williams, Zaslavsky, & Cleary, 1999). Some studies have found that although managed care plans describe significant efforts to manage and improve care quality, knowledge of these efforts largely fails to reach providers and result in improved quality of care for patients (Cukor et al., 2002; Fairbrother et al., 2000). Other research, however, has reported that providers find quality management strategies that focus on education and peer influence to be more productive than those that are regulatory or financial incentive based (Williams et al., 1999). Despite states' increasing their efforts to collect outcome data and lead quality improvement efforts over the 1990s, information on the efficacy of such efforts is limited (Landon, Tobias, et al., 1998; Landon et al., 2004).

Landon, Wilson, and Cleary (1998) provide a conceptual framework to explain the effects of managed care organizations on the quality of care. The model posits that managed care plans affect the quality of care through four mechanisms: (1) defining the nature and capabilities of providers, (2) directly interacting with beneficiaries (e.g., through reminders or incentives for preventive care services), (3) implementing broad population health-focused efforts, and (4) influencing provider behavior (e.g., through financial incentives or management or administrative strategies like chart review and performance feedback). This framework considers different units of organizational analysis and how they interact to influence care quality. The present research includes the units of providers, managed care plans, and the Medicaid office. The interview protocols developed for this research were guided by Landon, Wilson, et al.'s conceptual framework, and questions were designed to understand managed care efforts within these four mechanisms.

New Contributions

The present research builds upon Landon, Wilson, et al.'s (1998) framework to consider the roles of three stakeholder groups in Medicaid managed care and how they may affect efforts to manage and improve quality of care. Because prior research examining quality management efforts by Medicaid managed care date from the late 1990s and early 2000s, recent evidence following the striking growth of managed care enrollment over the past decade is limited and needed. This is problematic given enormous changes to health care following implementation of the Affordable Care Act and intensive efforts by the Centers for Medicare & Medicaid Services to increase federal and state oversight of Medicaid managed care. The present research aims to address this gap in the literature by presenting stakeholder perspectives regarding quality management in Medicaid managed care from Medicaid officials, managed care plan representatives, and providers. We specifically focused on understanding quality management strategies to improve care for children and women of childbearing age, since these two groups represent a substantial fraction of Medicaid managed care beneficiaries nationally, and, in the state of study, children and pregnant Medicaid beneficiaries are required to enroll in managed care.

Methods

Context

This article is part of a larger project that leveraged a novel policy experiment, in which a Northeastern state, following the 2010 exit of one of the three managed care plans serving Medicaid beneficiaries, randomly assigned the exiting plan's beneficiaries to the remaining two plans offered in the state. One of these two plans is a national, for-profit plan that serves both Medicaid and commercial populations. The other is a local, nonprofit plan that predominantly serves Medicaid beneficiaries. The national plan serves approximately 40% of the state's Medicaid managed care population, while the local plan serves 60%. Both these plans are risk based (rather than primary care case management plans). Approximately 15% of the state's residents have Medicaid coverage, and two thirds of the Medicaid population is enrolled in a managed care plan (Kaiser Family Foundation, 2018). Eligible populations include pregnant women and children aged 18 years and younger with family incomes up to 250% federal poverty level and parents of children aged 18 years and younger with family incomes up to 175% federal poverty level. Each of the aforementioned populations must enroll in a managed care plan (i.e., mandatory managed care enrollment). Dual-eligible populations are enrolled in Medicaid fee for service; disabled populations have a choice of fee-for-service or managed care.

Design and Sample

This study included 25 key informant interviews with stakeholders in the Medicaid program in one Northeastern state. This included 16 interviews with physicians and nurse practitioners who provided care to Medicaid beneficiaries, 5 interviews with representatives of the two Medicaid managed care plans in the state (2 interviews from one, 3 from the other), and 4 interviews with Medicaid officials. Plan participants included two chief medical officers, two medical directors, and a director of quality. Provider participants included 11 pediatricians (of which 2 were residents), 1 pediatrician/internal medicine

physician, 1 family physician, and 2 obstetricians. Practice settings for these providers included small private practices, community health centers, and large hospital-based clinics. Two providers reported practicing in patient-centered medical home settings. The proportion of providers' patient panels enrolled in Medicaid varied from 5% to 90%.

Procedures

We first sought the involvement of the state Medicaid office and then recruited the two managed care plans in the state that serve Medicaid patients. In the Medicaid office, we recruited and interviewed experts about contracting with managed care plans, quality management initiatives, and outcome measures. In the two health plans, we initially contacted the chief medical officer and then interviewed representatives who were knowledgeable about strategies employed to measure and improve quality of care. We also interviewed providers: An email was sent to provider listservs and state provider organizations requesting that providers participate in a telephone or in-person interview. Providers were eligible to participate if they cared for Medicaid enrollees. Interested participants were encouraged to contact the study's project coordinator. On completion of each provider interview, we also requested information about other providers who might be interested in participating (snowball sampling). Providers were compensated with a $50 gift card for their time.

Semistructured interviews were conducted with participants. Interview questions were designed to elicit participants' perceptions and assessments of the initiatives and strategies that Medicaid managed care plans use to manage the quality of care and health outcomes of children and women of childbearing age enrolled in Medicaid. We selected these populations because they represent three quarters of Medicaid enrollees nationally and because they are required to enroll in a managed care plan in the state of study; in this state, dual-eligible populations were generally not enrolled in Medicaid managed care plans during the study period. Medicaid officials were asked how managed care plans are identified and contracted with, how they deal with plans that exit the Medicaid market, which measures are important in measuring quality of care and outcomes, how quality data are generated and used, and what strategies the plans use to improve quality. Managed care plan representatives were asked about plans' efforts to measure and improve quality of care, the quality measures that are prioritized, strategies to improve outcomes, how outcome data are collected and used, and how providers and beneficiaries may be included in these efforts. Provider participants were asked questions about their practice, quality and outcome measures they believe are important to the health of Medicaid beneficiaries, what strategies Medicaid managed care plans employ to improve quality of care and outcomes (including provider and patient-focused strategies), and how they interact with managed care plans. See the Supplemental Material for the interview protocols. Interview protocols were pilot tested (three pilot interviews with Medicaid officials, two with managed care representatives, and three with providers) and then refined to enhance clarity. Individual interviews took place in participants' offices or on the phone, and each lasted about an hour. All interviews were audio recorded (with participants' consent) and transcribed for data analysis. This study and its materials were approved by the university's institutional review board.

Analysis

Interviews were qualitatively analyzed to identify themes and patterns of responses across participants (Crabtree & Miller, 1999; Miles, Huberman, & Saldana, 2014; Padgett, 2012; Weston et al., 2001). First, we developed a preliminary coding scheme based on the questions included in our interview protocols. We then adjusted the scheme in an iterative fashion through discussion by the analysis team members to add codes and refine code definitions; additional codes were added when unexpected or additional material emerged from interviews.

Initially, all team members individually reviewed and coded two transcripts of each of the three participant types (providers, plan representatives, Medicaid officials). In subsequent meetings, the team refined the coding scheme and associated code definitions according to their fit to the transcript data; the team also discussed preliminary patterns (or themes) emerging from the data and reconciled coding of the first transcripts. Once analysis of the first interviews was completed, the process was streamlined by dividing into two subteams of two or three members each, with each team member coding the transcripts independently, then meeting in the subteam to reconcile the codes and discuss potential themes. Membership in these subteams rotated, and the full team met regularly to discuss emerging themes, track prevalence of these themes across transcripts and sites, and search for alternate and confirming evidence in the transcript data.

During analysis, an audit trail was kept, which recorded ongoing team decisions, including selection and definitions of codes and discussion of emerging themes and competing interpretations (Curry & Nunez-Smith, 2015; Holloway & Wheeler, 1996; Lincoln & Guba, 1985; Miles et al., 2013; Ritchie & Lewis, 2012). Coded data were entered into the qualitative software package NVivo to allow for data management.

Results

Interview participants described attempts to manage and improve quality of care for Medicaid managed care beneficiaries. Although there was significant overlap in the efforts and associated outcomes that the three types of participants described, there were also discrepancies in perceptions across provider, managed care plan, and Medicaid office participants about the efficacy of these efforts. The resulting themes and example quotes follow, separated by type of participant and by whether strategies to manage care quality target providers or beneficiaries.

Managed Care Plan Representatives Described Significant Efforts to Manage Care Quality

Efforts to Manage Care Quality Included Strategies Targeting Care Providers.—Managed care plan representatives described how they attempt to manage care quality by targeting providers. These strategies included giving providers feedback on their performance on specific measures, providing incentives to physicians who meet or exceed standards, and engaging with providers for care management.

Plan representatives described that they commonly give providers updates on their performance.—This feedback typically prioritizes and places value on HEDIS

measures. One health plan representative discussed a system of giving physicians lists of members who did not receive recommended quality measures:

> One of the things we do is HEDIS tracking or interim reporting… So if it looks like there's a measure that's lagging behind, or that we're really worried about then we might take, let's say the people who look like they may end up being noncompliant for this year.… We can produce lists of, quote, I hate it, but "noncompliant members." We can say to a practice, "Well here are the people assigned to you who haven't yet this year met this HEDIS service. You might want to give them a call." The practices typically really like those. I mean, it can be big lists, but it's really helpful to have that really specific information for them. And so then they reach out to their patient. Or they say to us, "Well the person actually had the service." And we're like, oh that's good. You know because all the information I have are little bit behind right now.
>
> (Plan Participant 2)

The health plan representative described that although plan data are sometimes lagging behind provider-level data, providers still find this strategy helpful for patient care management. In addition to simply providing physicians with their own data, plans may also compare their performance with their peers:

> Sometimes we'll contact them directly to say, "Here's your data. Did you know that you're only doing 60 percent when everybody else is doing 80 percent," and then, "What can we do to help? Do you need information from us? Did you realize… these women were falling through the cracks, or these children were falling through the cracks?" For most primary care physicians it's welcomed because they're not looking necessarily at the same things we are. So they may not have their EMR set up to track these things. There are some that are put off by it, obviously. They don't like to be looked at.
>
> (Plan Participant 1)

Plan representatives reported that they used provider incentives as a strategy to help manage care quality.—One plan representative described pay-for-performance efforts to improve provider performance on specific measures, which they perceived as efficacious:

> For a long time we've used pay-for-performance based on aggregate quality measures, although we've also, at times, set up programs which were for one individual measure out of ten of concern for a particular provider group.… We will say, for instance, "Look, your mammography rate seems unusually low. What do you think? And how about if we… pay you a performance stipend for every person, every click, if you will. We call it pay-for-click. You can move this in the right direction so that we get up to 90th percentile or 80th percentile." And I think that all of these approaches work.
>
> (Plan Participant 5)

Another plan representative described payments for meeting set standards of care:

> We have incentives for prenatal and postpartum care, both on the provider and the member side.… The incentive is a dollar payment to both physicians and [beneficiaries] if they meet the standards for adequacy of prenatal care and if they get the postpartum visit within the appropriate timeframe.
>
> (Plan Participant 1)

Plan representatives also described efforts that included active engagement with providers.—One health plan representative described a cobranded initiative to reach out to plan beneficiaries:

> We have a cobranded initiative where we work with providers that represent probably 35 percent of our patient population, and … we actually go out to those offices … and we identify the offices' patients that have not come in for service.… We create a letter that has [the plan's] logo and the practice's logo, and on their behalf we send out the letter to the member saying, "Please come in for services." The same time that that letter is outgoing we're also making phone calls … to say, "Please contact your PCP. You may be due for services." … The providers are very well engaged in it, they appreciate it and they actually participate in the review process with us, so my clinical practice consultants are actually working with those sites. They send the member data in advance so that the providers can review it and say, "No, don't mail this letter. That person's not a patient," or "Yes, mail this one." They also take those lists, the mailing lists for that particular initiative and some sites actually incorporate that information into their EMR so that if that person does call for an appointment they have a note in their EMR that says, you know, sent a letter from [plan], so that they're kind of tracking the ways that they touch them as well.
>
> (Plan Participant 3)

This cobranded initiative also used plan staff called "clinical practice consultants," who another plan representative further described,

> I think probably one of the most effective interventions that we have is our … clinical practice consultants. They are nurses who have really good analytic heads also, and they go into provider offices "to collect data," but what they also do is they get to know the staff in the office and they begin to talk with them about how their office works, what they do, and then they are able to share with that office, "here's what your results show," and then drill down to the with the office to say, "how can we improve."
>
> (Plan Participant 2)

Plan Representatives Described That Strategies to Manage Quality of Care Also Targeted Beneficiaries Directly.—Managed care plan representatives also described strategies to manage care quality that target beneficiaries. These included outreach and reminders, incentives, a combination of outreach plus incentives, and more active engagement through beneficiary advisory boards.

Plan representatives described efforts to reach out to plan beneficiaries who might have lapses in care.—Sometimes these efforts were broadly targeted to all relevant beneficiaries:

> One of the great things that we do is a birthday reminder at age one for lead screening, so we'll send out, at the first birthday that the child needs to be screened for lead. We also have a telephonic system for immunizations. That's an automatic call that goes to the parents or guardian of the child, and it's really to remind them that there's a milestone that's coming up.
>
> (Plan Participant 4)

Other efforts were more specifically focused on "noncompliant" members:

> If people are not looking compliant, we will send a targeted letter to those people who we don't have claims demonstrating that they're meeting what we would like or what the standards are.… This is a claims-based thing. We use the same kind of HEDIS standards and if they are "adherent," they don't get the letter.
>
> (Plan Participant 4)

Plan representatives noted incentive programs to try to promote appropriate use of care by beneficiaries.—Such representatives commonly described both monetary and non-monetary incentives. One representative described a financial program:

> We also have member incentive programs, so right now members who are eligible can receive 25 dollars for completing their mammogram. They can also receive 50 dollars if they're a diabetic: 25 dollars for their eye exam and then 25 dollars for their lab work. Then also we incentivize women who need to have a postpartum, so they would get a gift card as well, worth 25 dollars.
>
> (Plan Participant 3)

Plan representatives also described efforts to reach out to beneficiaries and ultimately reward them for care utilization.—One representative explained their plan's program that focused on managing care for pregnant women:

> It is a web-enabled app that pregnant moms can get; we offer it broadly through the prenatal care providers, and then once the woman signs up, she gets messages that come through based on where she is in her pregnancy, like, "Ooh you might be feeling nauseous today. Here's what we can do about that." Then she also tracks her prenatal care appointments, so then we get those prenatal care appointments, which make us very happy, so we have some record that that occurs.… Then there's rewards they can get, and it's all pregnancy and baby appropriate rewards depending on where they are, and then I think it continues through for six or 12 months after the baby's born. So that's been a great program. We've gotten some decent press around that. People really like it.
>
> (Plan Participant 2)

Another plan representative identified other plan strategies along with reasons why outreach and incentives must be appropriately targeted and designed:

> We changed the incentive program—the previous one we didn't think was at all effective because the mailing strategy, it went out with a big packet of materials for [our prenatal program], [an] informational packet that goes out to every women who becomes pregnant in the plan, and so it was sort of buried in there, the incentive to get the prenatal and postpartum care. So we restructured it and made it a separate mailing and put information in the hands of both the providers and the member so they could start from either direction. The provider could say, "Okay, here's an opportunity for you to get some additional money if you get the care." It's only about three or four months into the effectiveness. It definitely is working better than the previous program in terms of the numbers that we see coming back. Whether it's going to change our rates, that'll be a while before we can tell that.
>
> (Plan Participant 1)

Plan representatives also considered how member advisory boards could be better involved.—One representative highlighted the value of creating shared goals with members:

> We're really engaged and we have a member advisory board and even any individual care plan is created by the member. It's not us telling them what they need to do per se, it's about creating shared goals.… I think that's why we have a lot of success in sort of helping people turn corners and we have a whole network of staff who are dedicated to helping them get housing or transportation or food. Respite, skilled nursing … and we look very much at the whole.
>
> (Plan Participant 4)

Another representative indicated how the member advisory board provides necessary feedback about plan strategies:

> [We get feedback about quality management programs i]n a couple of ways. We have a Member Advisory Committee. So we meet with members periodically and talk with them. I think members usually generally like incentive programs, as long as they're not too complicated.… One way to get feedback is, if we offer an incentive and nobody takes us up on it, probably not a good idea. Either people aren't interested or it's too complicated.
>
> (Plan Participant 2)

Medicaid Officials Reported That They Made Managed Care Plans Responsible for Quality Management

Medicaid office representatives described why they left quality management to the plans, but they also described problems with doing so. A Medicaid official described the benefit of holding managed care plans responsible for quality management:

> We will never have customer service the way we can buy in the health plans. We could never have care management in the way we can make the health plans do it.

> So we are better off being purchasers and overseers than we can if we try to build it ourselves.
>
> (Medicaid Official 2)

Medicaid representatives thus described leaving plans responsible for quality management, and also described a thorough knowledge of plan efforts to do so, described next.

Medicaid Officials Discussed Managed Care Plan Efforts That Target Providers.—Despite this impression of improved customer service, Medicaid officials did not find plan strategies targeting providers to be especially helpful:

> We pick a measure in which our plans perform below a certain percentile, usually the 75th percentile.… I would say in general that's been a rather unsatisfying process. The plans are not particularly sophisticated in how they do quality improvement … they do a lot of posting things to a website, sending providers notifications through e-mail, publishing guidelines, you know plan-specific guidelines. Things that in the hierarchy of quality improvement methodologies would tend to be at the lower rungs.
>
> (Medicaid Official 1)

This Medicaid participant continued, describing plan efforts as minimal or limited:

> They do the standard things, like each payer publishes guidelines and disseminates them. Sometimes they disseminate them actively and sometimes they disseminate them in a more passive way, like posting them on the portal. They have provider newsletters that they use and when there's an issue of particular concern to them they'll often highlight it in the provider newsletter. They will occasionally do some academic detailing, either with a high volume provider or provider as an outlier. I don't think they do that very much cause it's costly. I would say they do some education in person, face to face. And then they have some payment incentives around quality that vary by provider type, vary by specialty, and vary in how much the incentive is for.
>
> (Medicaid Official 1)

Medicaid Officials Also Discussed Plan Efforts That Target Beneficiaries.—Medicaid officials described how plans use incentives and care managers to address quality improvement by targeting beneficiaries. One participant discussed a person-centered approach to care management:

> Their care management programs have specific programs to reach out to women who are pregnant, for example, and ensure that are they going to their prenatal visits. And if they're not, what's the barrier and how can they assist? They have programs like that within care management, condition specific, if you will, like asthma, diabetes, etc. Then, within the care management process, they have to do an initial health risk assessment with folks. That can trigger … enrollment into care management … to help folks navigate the system. Understand what their benefits are and what they have available to them. Advocate, if they feel like something

> really is medically necessary. Assist with social issues or needs that may arise that could be really the issue.… I think more so now than ever, it's really looking at the person holistically and having a person-centered approach.
>
> (Medicaid Official 3)

Another participant indicated that plans might take care management a step further by offering incentives to beneficiaries who participate:

> But then I start giving them rewards. If you talk to a care manager, and you start talking about what your issues are and they're able to help you, every time you spend twenty minutes on the phone with a care manager.… Here's a $25 gift card for engaging with care management to help you get your health on track.
>
> (Medicaid Official 2)

Providers Reported Varied Perceptions About the Value of Medicaid Plans' Quality Management Strategies

These perspectives ranged from a lack of awareness of any programs, to feeling that the programs were not effective, to believing that they were very helpful.

Some providers reported that they were not aware of quality management strategies and were skeptical of their value.—A number of providers were unaware of any plan efforts to manage care quality. One provider said,

> Ah, strategies that they use to promote … you know, I don't know because I'm sitting down here at the bottom of the heap. So whatever strategies there are, if they're out there, I really don't know about them. I'm basically seeing patients and actually I'm happy not to hear about the various strategies. I've been reading about strategies for this and that, and I'm thinking, really? You think it'll make a difference?
>
> (Provider 12)

Another provider acknowledged that plans may have strategies but that they don't have the time to focus on communication from the plan:

> Not that I've specifically seen but to be fair to the managed care plans, they may be posting it on their provider portal, and I honestly just don't have the time in my day to log in to the portal to read the information there so I am unfortunately somebody that I need to see it in snail mail for it to grab my attention.… I just haven't figured out how to put [using the portal] in my workflow because the flip side of having quality measures and stuff is we have to document that we did that, and that takes more time so I have even less time now than I did ten years ago to look up stuff in third party places.
>
> (Provider 2)

Other providers said that plans made no efforts to manage quality.—Other providers gave the plans less credit, and when asked about their thoughts regarding strategies managed care plans use to promote quality of care, they responded,

> You mean the lack therein? … Well if they've offered [promotional or informational materials] to me it's ended up in the trash, so probably not very often because I don't remember it arriving to me. Do they offer it to patients? They might. I haven't heard about it.
>
> (Provider 11)

Others took this sentiment a step further, including one provider who saw no value to the managed care approach:

> I would say, my opinion is that managed care is a complete waste a time. Get [plans] completely out of the picture. Why are they there? I don't understand why they exist. There's no need for them. All they do is provide this middle layer of nonsense that is in the way of people getting care. I don't see them as a benefit for my patients. I don't see how they're helping my patients.
>
> (Provider 3)

While providers described receiving performance feedback from managed care plans, they also said that this feedback was not sufficient.—The primary strategy that providers described plans using was provider feedback on important, almost exclusively HEDIS-based, measures. One provider said,

> The health plan identifies to increase HEDIS measures that need improvement, and we get a communication about it, and depending on the measure, and depending on the year, there might be some programs related to improving those.… They tell us what the HEDIS measure is and then where we're supposed to be.
>
> (Provider 16)

Sometimes this feedback took the form of lists of noncompliant patients: "They will, sometimes, come to us with lists of patients, like we think these patients are overdo for care" (Provider 1).

While acknowledging the feedback, provider participants described feedback as either not helpful or that the focus on HEDIS measures was not sufficient. One provider considered HEDIS measures a minimum of what should be required by a physician: "They do have the HEDIS data.… But if you're not doing these things, you're not really doing your job as a pediatrician. If a practice wasn't doing these things, I wouldn't [want to] be involved with that practice" (Provider 3). Other providers described problems with the quality of the feedback they receive from plans. One provider discussed problems associated with lists of noncompliant patients:

> The quality of the list has been our issue. My experience, again, in terms with [plan], was when they brought those lists … between a quarter and a third of the "potentially not meeting care standards" were accurate.… As much as we want that data and want to be able to take those patients down, having to sift through so many of them to find the ones that we need to was frustrating.… Patients that we're seeing regularly often don't show up on the list and then patients that we clearly never have seen them, they've never had any care with us [do show up on the list].

> … Some of it is the disenroll automatic reenroll, that assignments seem to be up for grabs again when people unintendedly don't renew in time.
>
> (Provider 1)

Other providers expressed a desire for programs in addition to feedback on critical measures, including this physician:

> It doesn't help me if they send me something to check off different outcomes. For example, if I have a whole bunch of obese kids, I need to have a program to put them into, [and] the insurance [has] to be actively involved in that, and cover the services and make it seamless. But [the plan] telling me that this kid is obese isn't helpful.
>
> (Provider 6)

Providers described receiving modest incentives from managed care plans but noted difficulties with communication and documentation.—Provider participants also described provider incentives from plans. This provider discussed receiving an incentive to complete risk assessments for pregnant patients:

> Early prenatal care. That's one place where Medicaid has actually some dollars on the table for the providers to fill out the assessment forms on pregnancy, and be able to manage them accordingly.… Any time we have a new pregnant woman, we're supposed to do a risk assessment form that is sent to [the plan].
>
> (Provider 16)

However, participants noted a number of problems around incentives, including poor communication and financial incentives that were too small considering the amount of work required to earn them. One provider described that the incentives did not make up for the amount of work required to receive them:

> To be candid there's so much book work it's sort of a wash because the staff have to do so much paperwork to document all of this stuff and fill in all this stuff, I'm not sure that we actually make money off of it. In other words, the administrative cost- I don't see the actual benefit of the programs.
>
> (Provider 5)

Another provider described an incentive that was problematic due to poor communication between the plan and the practice:

> Unbeknownst to us, we had agreed that we would take part in a small pay for performance program.… And in October, [the plan] approached us with lists of patients that supposedly not had their three-year-old visits and adolescents who had not had their chlamydia screening … this was the first we ever heard that this was even a performance measure for us.… So we went through their list and about three quarters of them actually had had whatever the thing was. We sent them documentation. And then we held Saturday clinics to get everyone else through. And we ended up getting the incentive but it was just really frustrating and annoying. I mean, basically the incentives would get spent on Saturday clinics to

> get ‘em through. If we had known, Day 1, that we were part of that contract, we could’ve paid attention to it, run reports, figured out how we were doing and kind of tracked it throughout the whole year.
>
> (Provider 4)

Care coordination was also cited as a problem.—One provider participant noted that plans have quality management strategies around care coordination but that the value of these strategies varies:

> I think that multiple plans offer care coordinators and I have had very variable success with that. I’ve had one or two times when I’ve worked with them and found someone who could take on responsibility for what I consider care coordination, like helping the patient make connections and give them viable options for referrals especially mental health referrals, but more often I have run into a person who just sends me paperwork back that I could have easily gotten the first time if I had that flexibility so a lot of times I found the labels misleading and then kind of you waste some energy pursuing that support and it’s really not the support that it’s billed as.
>
> (Provider 1)

Providers Discussed Managed Care Efforts to Manage Quality of Care That Target Beneficiaries.—As with strategies that target providers, provider perceptions of these beneficiary-based strategies were mixed.

Some providers were not aware of any managed care strategies targeting beneficiaries.—Provider interview participants were frequently unaware of strategies managed care plans used that targeted beneficiaries. Providers did not seem to know if patients were receiving incentives or materials directly from plans: “I don’t know if they do any direct mailings to their patients, but I have not seen them specifically, no” (Provider 2). Whether patients were not receiving any materials or such materials were not prompting them to see their physicians is not clear from the narratives. If patients receive materials that do prompt them to visit their physicians, provider participants did not express that they were telling their physicians about it:

> I do not recall seeing [materials], and my patients certainly don’t bring them with them. I can tell you, I never heard any of my patients come to me and say, “I got a brochure from [plan B] or from [plan A], and they sent me, you know, why don’t you do this, or do that, or whatever.” But maybe they get them.
>
> (Provider 6)

These possibilities indicate gaps in communication among plans, providers, and beneficiaries.

Some providers discussed managed care outreach to beneficiaries.—Some provider participants said that they were aware of outreach or materials from managed care plans that target beneficiaries. One provider described some materials as helpful:

> We have promotional materials all the time for the health plan.… We get materials about the program and how to tell people to enroll, and all of that stuff… Patients tell us that they use [the programs], and that it can help ‘em! And they ask questions about it.
>
> (Provider 14)

Another provider noted how such outreach is negatively affected by problems like unstable housing and lack of health literacy:

> I send out newsletters and notifications of benefits, like, say encouragement to make your first dental visit and I’m sure [plans] send some of that out to patients too. Once again, the issues of other things that impact patients such as housing and not having a correct address, or not having a correct phone number affect the effectiveness of that.… I think they certainly can [improve care quality]. I think that even though patients supposedly have a package of what’s available to them, and what’s covered under their insurance sometimes they’re not aware of it and the more you hit them in the face with, you know, “Your child’s covered for dental care, and in fact there are dentists who really will see you, and this is where you find the list,” the more times that they hear that and the more avenues in which they see that, the better. So things like posters and letters, and primary care provider reminders, those are all helpful.
>
> (Provider 9)

Other providers discussed incentives for beneficiaries.—A few providers said that they were aware of incentives that patients might receive from managed care plans, but they noted that these incentives were not appropriately communicated to the providers:

> They offered some additional things like [for] people that come in on time during the summertime for their well child visit, they have kind of giveaways, they were sort of incentivizing people to make the time to do it, like back to school equipment, backpacks, books, other things. They were kind of fun but it was kind of given to us at the very last minute and we couldn’t really take good advantage of it, it wasn’t you know two months’ notice that they were looking to do something like that would have let us block out blocks of well child visits so we could easily book and really make the most out of things like that, so a little more coordination with what they’re interested in doing would be helpful.
>
> (Provider 1)

> Another provider concurred that providers were not typically made aware of patient incentives: “I mean, from time to time they do incent families to come in for things, but I don’t know—I mean, we usually don’t get a heads up about that, so I never know what they’re getting”
>
> (Provider 4).

Provider Participants Described Their Ideas for Improving Quality Management.—Their ideas for improvement centered on improved communication

between plans and providers. One provider described a desire to hear more about patient outreach and suggested that plans seek input from providers:

> I would also ask if there were times when they were doing mailings, if they are sending things directly to our patients, we would love a copy to come to us, like if they were going to do outreach we would love to know in advance so that we could anticipate questions or influx of patients with significant issues and be prepared for it.… If [plans] have interest in incentive programs … to kind of draw on a little bit or seek input about what might work from their practices, that would be pretty neat.
>
> (Provider 1)

Another provider suggested better communication and specifically indicated that provider input might be helpful in determining appropriate measures to focus efforts on:

> Most of the risk scoring that's done on patient populations use adult metrics, that are not good at predicting which children are going to be most expensive next year, or in the coming months, and I think one of the great opportunities that we have in [state] is we have two plans to work with. And if we could come up with a work group that would be able to really examine some of the social risk factors that are collected, along with some of the traditional health risks, I think we could really come up with a much better way to predict resource needs, in order to prevent bad health outcomes.
>
> (Provider 4)

Last, one provider described a general wish for greater cooperation:

> They could work cooperatively with providers, they could listen to providers, they could worry a little bit less about their bottom line and work towards improving care instead of just trying to keep themselves in business. I think if they were to work cooperatively, to meet with providers to set common goals, to open lines of communication, all of which … are absent.
>
> (Provider 7)

Discussion

Medicaid officials, managed care plan representatives, and providers described attempts to manage and improve quality of care for Medicaid beneficiaries. Although there was overlap in the efforts and associated outcomes that the three types of participants described, there were varying perceptions overall about the effectiveness of health plans' quality management strategies across provider, managed care plan, and Medicaid office participants. Managed care plan representatives tended to describe quality management efforts as robust and included strategies targeting both providers and beneficiaries. These strategies included provider and beneficiary incentives, providing feedback on outcome measures to providers, sending promotional and informational materials to providers and beneficiaries, and efforts at care coordination. Medicaid administrators spoke more about their motivation for having plans be responsible for quality management and were less positive about the value of plans' efforts. Our sample of providers varied in their responses to plan strategies to manage care:

Some providers were unaware of strategies, others viewed the strategies as unhelpful or problematic, while still others viewed some strategies as valuable.

Across participants, a few strategies emerged as best practices, with most participants in agreement that they were effective. These included outreach and providing incentives to beneficiaries. However, it was also highlighted that outreach and incentives to beneficiaries would benefit from greater efforts by plans to communicate with physicians. Although previous research has suggested that the provision of performance feedback to providers may be a key strategy to manage quality of care (Williams et al., 1999), this did not emerge as a best practice in the present study. Although providers described performance feedback as helpful, many said that it was not sufficient in the goal of improving/managing care quality. Performance data must be accurate, valid, and reflect measures that providers consider to be important in assessing quality of care. Plans and the state Medicaid program described focusing their quality measurement efforts on collecting HEDIS measures, and although providers generally acknowledged the importance of these measures, they described them as minimally sufficient in characterizing quality of care among Medicaid beneficiaries. This finding may be driven by the use of these indicators among commercial and Medicare Advantage plans and the pragmatic need to use measures that have been validated and can be benchmarked to other populations and collected using existing data, thereby minimizing additional administrative burden. Despite the common focus on HEDIS measures, providers voiced skepticism about the validity of performance data as applied to their own patient population (including problems with identifying and properly attributing patients to practices). Such provider concerns about data may undermine plans' efforts to measure and feedback clinical performance measures to providers.

A key finding was the need for improved communication among managed care plans, providers, and the Medicaid office, specifically around managed care efforts to manage quality of care. As suggested by Landon, Wilson, et al.'s (1998) conceptual model, care quality may be influenced through a number of pathways that may include targeting efforts at providers and beneficiaries but that the interactions among all stakeholders must underpin all efforts. As discussed by the study participants, the lack of awareness of managed care plans' efforts among providers not only seriously hinders the efficacy of these strategies but also causes frustration and significant administrative burden that may harm care quality. In addition, not all pathways outlined by Landon, Wilson, et al. were raised by the plans. Plans did not describe selectively contracting with high-performing providers or more broad population health–focused efforts. Efforts instead focused on directly contacting beneficiaries and influencing provider behavior through the provision of performance data and some incentives. Interview participants discussed that Medicaid managed care plans made some efforts to coordinate care for their beneficiaries. However, it is possible that plans may be duplicating roles already in place in some clinics through the expansion of patient-centered medical homes. As a prominent model of health care reform that has been supported and promoted by the Affordable Care Act (Davis, Abrams, & Stremikis, 2011), care coordination is a primary function of patient-centered medical homes (Agency for Healthcare Research and Quality, n.d.). However, the siloed administration and payment of health care complicates the provision of coordinated care and creates the potential for efforts to be duplicated (Rich, Lipson, Libersky, & Parchman, 2012). Results of the present research

suggest that care quality may be improved if plans made greater efforts to communicate with providers around efforts that may be most helpful and not duplicative.

Unmet social need is an additional theme that arose during these interviews. Participants described efforts by plans that attempt to address social needs, including incentive programs that are designed to help educate beneficiaries and connect them with needed resources. Provider participants specifically discussed the challenges of health literacy and unstable housing among their Medicaid patients. In our other work using these data, we present the perspectives of these providers who highlight challenges of low Medicaid reimbursement, inadequate care coordination, limited access to behavioral health care, and lapses in Medicaid coverage resulting from renewal and enrollment policies, all of which are associated with unmet social needs (Gordon et al., 2018). Adding further complexity to these challenges, previous research has found that Medicaid managed care plans are hindered from attempting to directly address social determinants of health of their beneficiaries by regulatory requirements, and authors suggest, among other strategies, that plans be more engaged in regulatory decision making (Gottlieb, Quinones-Rivera, Manchanda, Wing, & Ackerman, 2017). Although the providers we spoke to suggest that plan efforts should be informed by greater communication among plans, providers, and the Medicaid office, these findings indicate that efforts should also include the perspectives of beneficiaries. Future research would also be improved by examining if and how beneficiaries are able to access and participate in plan quality management strategies.

It is important to consider the underlying policy context of this study. The interviews presented here were conducted between February and October of 2016. In April of 2016, Centers for Medicare & Medicaid Services issued the Medicaid and Children's Health Insurance Program Managed Care Final Rule, which was the first major update to Medicaid and Children's Health Insurance Program managed care regulations in more than a decade. Several components of these regulations may have implications for the work discussed here. The rule grants states the authority to require plans to implement value-based purchasing models. We heard from providers that the incentive reimbursements were not enough to promote quality. While this rule may increase states' flexibility to engage in pay for performance, it has yet to be seen whether states have increased incentives enough to alter provider behavior. The regulations also include improvements to data collection and standardization. While it would be difficult to determine whether these improvements resulted in concrete changes for this particular state, the updated regulations have the potential to address concerns raised by provider participants' regarding data accuracy. This could be an area for future research. Last, the regulations grant states and plans increased flexibility to communicate directly with beneficiaries. Plan participants reported that they were already communicating directly with beneficiaries/patients through mailings but that providers were not made aware of these communication efforts. The new regulation could potentially increase the ease with which plans/states communicate directly with beneficiaries. If so, our finding about whether or not communication with beneficiaries is an effective strategy is especially relevant.

With 81% of Medicaid beneficiaries enrolled in managed Medicaid (Kaiser Family Foundation, 2016b) and most Medicaid expansion states enrolling all newly eligible

beneficiaries in managed care plans (Smith et al., 2015), it is important to understand Medicaid plans' efforts to manage and improve quality of care for this vulnerable population as well as providers' level of awareness and perceptions of these strategies. Medicaid managed care enrollment has been driven by two main factors: (1) that managed care plans are better positioned to integrate health services and oversee the delivery of care than the state Medicaid program and (2) financing care through capitated payments to plans offers a great deal more of predictability for state budgets. However, there is limited evidence about how state Medicaid programs, as a purchaser of care, oversee the quality of care delivered to private Medicaid managed care beneficiaries. This study suggests that in this state representatives from the Medicaid office were closely aware of plans' quality management strategies and their descriptions closely aligned with those of plan representatives. Also, the Medicaid office used common measures (HEDIS) to benchmark plan performance nationally. However, the state Medicaid office did not prescribe specific quality management strategies to health plans, believing them to be the responsibility of the plan even when they believed the strategies to not be particularly robust.

Our study included a moderate amount of data by the standards of qualitative research—25 interviews with stakeholders in the managed Medicaid system. However, our results are not necessarily generalizable, as the individuals who agreed to participate may be different from others who did not participate. Additionally, it is important to note that we are especially limited by the inclusion of just 16 providers in the state. The experiences of these 16 providers may not be representative of the experiences of providers in the state more broadly. In recruiting provider participants, we informed potential participants that we were interested in learning about perceptions of how Medicaid managed care plans may influence quality of care. As a result, participants with particular viewpoints about Medicaid managed care, both positive and negative, may have been more likely to self-select. Also, because these interviews were conducted in one Northeastern state, findings may not be generalizable to processes at work in other states, especially given the state to state variability that exists in Medicaid managed care.

Despite these limitations, these results are consistent with and expand upon the body of research conducted during an earlier period of Medicaid managed care growth during the late 1990s and early 2000s. Qualitative results describe how Medicaid managed care is perceived to be successful, insufficient, or lacking in specific detail by the participants interviewed here. Consistent with prior research, and despite managed care plans describing significant efforts to influence care quality, providers in our study indicated that they were often unaware of these efforts (Cukor et al., 2002; Fairbrother et al., 2000). However, as with prior research (Williams et al., 1999), some strategies were deemed valuable. While results of the present study suggest that provider incentives were not substantial enough to be worth the additional burden, strategies focusing on education and incentives for beneficiaries may be a valuable way to influence quality of care and population health in Medicaid managed care plans.

This qualitative study found that Medicaid health plans described robust efforts to measure and improve quality through performance feedback, beneficiary outreach, and provider-focused incentives, often targeting widely reported HEDIS measures. However, providers

were unaware of these efforts or reported them to be counterproductive since the performance data were thought to be inaccurate or limited and the modest incentive programs presented excessive administrative burden on physician practices. This research is an important step in examining how managed care plans structure their efforts and how critical stakeholders view the efficacy of these efforts. Results from this study suggest a critical area with room for improvement: communication among plans, providers, and the Medicaid office about the objectives and implementation of quality management practices in Medicaid managed care.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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