Partnerships for Quality Education
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and

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Conference Proceedings Executive Summary

Meeting the Challenge of Medicaid Managed Care: Best Practices for Clinical Care and Teaching

PARTNERSHIPS FOR QUALITY EDUCATION
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INTRODUCTION

On November 1 - 3, 2001, Tufts Managed Care Institute (TMCI) and Partnerships for Quality Education (PQE) held a national conference entitled *"Meeting the Challenge of Medicaid Managed Care: Best Practices for Clinical Care and Teaching."* The program was designed to give clinicians and faculty access to best practices and innovations in managing the care of Medicaid and low-income populations, taking into account current trends, model programs, research results, and new approaches to teaching. The program was attended by more than 150 physicians, nurses, and other health care professionals who practice and teach in academic health centers and affiliated settings that serve Medicaid populations. More than 25 presentations and interactive workshops, led by national leaders in their respective fields, addressed a broad spectrum of Medicaid managed care issues, all with a focus on teaching and real-world applications.

> MEDICAID MANAGED CARE HOLDS PROMISE AND OPPORTUNITY FOR POLICY MAKERS, PRACTITIONERS, AND PATIENTS, IF THE "HIDDEN CURRICULUM" OF MEDICAID MANAGED CARE IS UNDERSTOOD AND PRACTICED.

MEDICAID MANAGED CARE: AN OVERVIEW

Medicaid is the program responsible for ensuring that our nation's most vulnerable citizens receive high quality and adequate health care. In the opening keynote address, "The Hidden Curriculum of Medicaid Managed Care: Past, Present, and Future," Lewis G. Sandy, MD, executive vice president of The Robert Wood Johnson Foundation, reflected on how the policies and practices of Medicaid constitute a "hidden curriculum" that speaks volumes about what it means to be poor and sick in our country. By looking at the **implicit** meaning behind the structure, function, and evolution of Medicaid, Dr. Sandy asserted that policy makers and practitioners, as well as those who train them, can gain insights into the promise and opportunity that Medicaid managed care offers.

What is the "hidden curriculum" of Medicaid managed care? To some extent, Dr. Sandy said, the policies of Medicaid managed care may be regarded as a utopian fantasy; they reflect a belief on the part of policy makers that the program can succeed in optimizing the delivery of care through contractual obligations, capitated rates, and a reliance on health plans to be patient advocates. The practice of Medicaid managed care also differs from the traditional Medicaid program in its emphasis on access to care and the ability of providers to offer care, as well as in its focus on holding organizations (i.e., health plans) accountable for costs and quality for both individuals and populations.

Finally, in the context of Medicaid managed care, the implicit attitude towards patients has evolved. Medicaid practitioners working in managed care environments are learning the importance of cultural competence and the non-medical determinants of health (e.g., physical environment, nutrition, personal behaviors).

Dr. Sandy urged everyone who teaches or practices in the Medicaid arena to become aware of how this hidden curriculum is incorporated into model practices and research. Equally important, Dr. Sandy encouraged attendees to improve Medicaid for the future by taking part more directly in shaping this curriculum, particularly in the context of managed care. By doing so, practitioners can better serve not only the children and families who depend on Medicaid now and in the future, but also the future generations of clinicians who will be caring for this population of patients.

WHAT IS MEDICAID?

In her opening plenary presentation, " Medicaid Managed Care: Expectations and Realities," Diane Rowland, ScD, executive vice president of the Henry J. Kaiser Family Foundation and executive director of the Kaiser Commission on Medicaid and the Uninsured, set the overall context for the conference by providing a detailed picture of the Medicaid program today. Medicaid is a combined federal and state program that serves a wide variety of people with disparate needs for health care and social services. Some are fairly healthy, while others may be very sick, but what they all have in common is poverty. Medicaid is the biggest program for the poor in the United States, providing coverage for 1 in 10 Americans and 1 in 5 children. She also noted that Medicaid is a major payer across the country, although its purchasing clout varies by state.

Historically, Medicaid has been a service-financing program for two populations: people eligible for TANF (Temporary Assistance for Needy Families) and people who have severe disabilities and/or qualify for Social Security Insurance (SSI). The program now covers:

- more than 40 million people of all races;
- 21 million children, 40% of whom are poor;
- more than 8 million adults in low-income families;
- 40% of births nationwide;
- medical and long-term care services for 7 million low-income people with severe disabilities

Altogether, these children and their related adults represent more than 70% of Medicaid enrollment. Yet, the costs associated with this large population represent only 25% of Medicaid spending. In general, the children are healthy and primarily need acute care services.

Medicaid also pays premiums and provides prescription drugs and coverage for long-term care for 6 million low-income elderly, or about 14% of all Medicare beneficiaries. Although people on SSI or with disabilities constitute about 27% of all Medicaid beneficiaries, they are responsible for more than 66% of all spending.

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The Problems with Traditional Medicaid

Robert E. Hurley, PhD, associate professor of Health Administration at the Medical College of Virginia, Virginia Commonwealth University, who spoke on the 2nd day of the conference, summarized the challenges that were facing the traditional Medicaid program prior to the introduction of managed care. In the period around 1980, the program was suffering from "the Medicaid syndrome"—a set of interlocking symptoms contributing to a spiraling of problems. The symptoms included low provider payments, which led to declining participation by providers. This, in turn, led to concerns about the caliber of participating providers. It also resulted in diminishing access to care for beneficiaries, who increasingly relied on emergency departments for attention. The Medicaid population received limited primary care, continuity of care, and preventive services.

Recognizing the many weaknesses of Medicaid, policy makers turned to managed care as a remedial strategy to improve a troubled program. Over time, state-funded Medicaid managed care programs began a concerted effort to combine the organization and financing of health care services in order to achieve a number of important goals:

- increasing access to mainstream care,
- improving quality of care,
- emphasizing preventive care,
- controlling costs of the program, and
- implementing controlled expansions of coverage.

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The level of enrollment varies widely by state. States also vary in whom they focus on for managed care enrollment. Initially the emphasis was on children and their parents, but the focus is beginning to shift onto the other segments of the Medicaid population. Despite the growth in enrollment, payments made to managed care organizations still represent only a small share of overall Medicaid spending. This is the case because children and their parents still represent the primary focus of this strategy.

The states have used two strategies for implementing managed care:

- One approach is the risk-based model, which is characterized by contracts with managed care organizations that are paid capitated rates to provide care for a defined population.
- The other strategy, known as primary care case management (PCCM), is a form of managed care unique to Medicaid. Primary care providers contract with the state agency to manage care by providing or authorizing primary and specialty care, including inpatient and outpatient hospital care.

A LOOK AT MODEL PROGRAMS

Plenary presentations at the conference offered two models for improving the delivery of health care services in a Medicaid managed care setting. The first program involves collaborative approaches to improving care for children and their parents. The second program focuses on a model for taking care of patients with serious illness and disability in a Medicaid managed care environment.

Improving Care for Children and Mothers

Richard J. Baron, MD, FACP, president and CEO of Healthier Babies, Healthier Future, Inc., described collaborative initiatives involving Medicaid/SCHIP plans: BCAP (Best Clinical and Administrative Practices) and Healthier Babies, Inc., in his plenary presentation "Model Programs in the Delivery of Medicaid Managed Care: What Works Now, What Could Work Better?"

BCAP is a $3.8 million initiative of The Robert Wood Johnson Foundation to work with Medicaid and SCHIP (State Children's Health Insurance Program) health plans to identify, pilot, and disseminate the best clinical and administrative practices. The goal underlying BCAP is to learn how to administer these kinds of plans more efficiently.

The BCAP program has several elements, including work groups that focus on specific topics, workshops to disseminate the findings of the work groups, toolkits that document what plans can do to improve their practices, and networking opportunities to promote further learning. The work groups are tackling the following five topics:

- improving birth outcomes,
- improving preventive care services,
- achieving better care for asthma,
- improving coordination and care for children with special health care needs, and
- improving coordination and care for adults with special health care needs.
- Each work group relies on a topology that encourages them to answer the following four questions:
  - How can plans identify the target population?
  - What do we know about the target population, and how do we know it?
  - How can we find and touch the target population?
  - What works to improve outcomes?
- For each step of the topology, the plans develop a quantitative aim, a measure for determining whether a change is an improvement, and a set of improvement strategies.

Dr. Baron also played a leading role in an effort to improve the collection of comprehensive clinical data for pregnant women in the five counties served by Pennsylvania's mandatory Medicaid managed care program. The four Medicaid managed care organizations worked together to standardize the prenatal risk assessment form, develop a relational database accessible to each plan's case managers, and establish a stakeholder corporation to control the data. The evidence suggests that the Healthier Babies program has achieved positive results of increasing the number of clinical encounters before and after delivery.

Dr. Baron strongly encouraged Medicaid managed care organizations to adopt a population-based approach to improving quality of care, although he acknowledged that the challenges are formidable, especially as the states deal with mounting deficits. However, in the context of a "thinning soup," it may be even more important to adopt a perspective that spreads the resources as widely as possible.

According to Dr. Master, Medicaid managed care can play an important role in meeting complex health care needs. However, the organization of existing services in a Medicaid managed care setting is not a good fit for people with severe disabilities. The challenge is to rethink how to use prepayment and redesign the roles of care providers so as to serve this population effectively.

Improving Care for People with Disabilities and Serious Illness

Turning to the smaller but far more costly population of Medicaid beneficiaries with disabilities, Robert Master, MD, chief medical officer of Neighborhood Health Plan in Boston, presented a model based on the Community Medical Alliance and its clinical programs in his address, "Meeting the Challenge of Medicaid Managed Care for Patients with Serious Illness and Disability." The Community Medical Alliance focuses primarily on meeting the needs of Medicaid-eligible individuals with AIDS and severe physical disabilities.

Typically, these Medicaid beneficiaries receive care through the classic fee-for-service system. In this system, primary care is often ineffective or marginalized. Instead, care is provided by teaching hospitals, which are technically excellent but poorly organized, so that patient care is fragmented with multiple specialty providers. Expenditures for medical services go disproportionately to "back end" hospital care, with little ability to redistribute these dollars to home and community services. Finally, this system disconnects the behavioral health services that beneficiaries need from the medical services they get.

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The program he described—the Community Medical Alliance (CMA) Model—is part of the Neighborhood Health Plan, a Massachusetts statewide, nonprofit HMO with about 130,000 enrollees, most of whom are in the Medicaid program. Approximately 550 members are eligible for the CMA, which functions as a fully capitated managed care plan for people with disabilities and chronic illness. Through a contract with Massachusetts Medicaid, CMA enrolls SSI-eligible, disabled populations in return for premiums that have been adjusted for health status.

This model relies on a team approach to deliver 24-hour-a-day access to primary care and create a network of highly trained and skilled clinicians to serve these patients. The primary point of contact is the nurse practitioner that takes responsibility for care management, representing a shift in the traditional paradigm where the physician is the focal point for care. The CMA model, however, offers more than a team approach with a nurse practitioner providing case management. Another key element in the CMA model is that the subset of physician practices working with these populations has achieved a common vision of appropriate ways to deliver care. For example, these practices leave half the day unscheduled so practitioners can respond to problems as they arise. Also, the model moves medical decision making into the home, which is especially valuable for a population with limited mobility.

Since the CMA program began in 1992, the overall costs of care for the population it serves have declined relative to the costs in the fee-for-service system. What drove this reduction in costs was a dramatic reduction in the costs associated with hospitalization. The CMA program has saved about $1,000 a month through decreased admissions and shorter length of stay. In the CMA program, spending has been reallocated to primary care, DME (durable medical equipment), and home health.

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While the needs of the population served by the CMA model may be unique, the lessons learned from this approach can be applied to a variety of settings. In essence, the challenge for managed care organizations is to look for opportunities to redesign primary care by developing a team model and moving the focus of front-line decision-making beyond the physician. It is critical to remember, however, that this model can only work in the context of risk-adjusted capitation for high cost, high-risk subgroups.

THE IMPORTANCE OF RESEARCH IN MEDICAID MANAGED CARE

As part of his plenary presentation, "Research in Medicaid Managed Care: What We Know, and What We Need to Know," Dr. Robert Hurley reviewed what research over the past two decades has revealed about the impact of managed care and commented on what we still need to know.

The research suggests that Medicaid managed care has achieved the goal of creating a "contractually-obligated medical home" for Medicaid enrollees. He commented that this could be regarded as the principal contribution of managed care to the Medicaid program. Researchers have also documented improved access to care and a reduced identification of the emergency department as the medical home. However, more recent data point to a possible and troubling reversal of this latter trend. Research has also found that care is more concentrated with primary care physicians, suggesting that continuity of care may be improved in managed care.

GENERALLY, SATISFACTION WITH MEDICAID MANAGED CARE IS HIGH AND COMPARABLE TO, IF NOT BETTER THAN, SATISFACTION WITH TRADITIONAL FEE-FOR-SERVICE MEDICAID. ANOTHER IMPORTANT FINDING IS THAT, IN MOST PROGRAMS, PLAN SWITCHING (I.E., VOLUNTARY DISENROLLMENT) IS VERY LIMITED.

Remaining questions about access and utilization include:

- Does a stable medical home lead to better care?
- Do PCCMs and HMOs provide comparable access?
- Do beneficiaries have different experiences with a private physician versus a health center as a medical home?
- Is emergency department use increasing and why?
- How do persons with disabilities and chronic illness fare in Medicaid managed care programs?

Generally, satisfaction with Medicaid managed care is high and comparable to, if not better than, satisfaction with traditional fee-for-service Medicaid. Another important finding is that, in most programs, plan switching (i.e., voluntary disenrollment) is very limited. Finally, there is some evidence that limitations on specialty access or the availability of preferred medications lead to dissatisfaction.

There are relatively few thorough studies of quality (although more than were ever done in traditional Medicaid). Some studies have documented improvements in immunization levels and prenatal care; others show relatively few differences in care processes and outcomes between managed and traditional Medicaid.

Areas ripe for further research include:

- Can consistent patterns of quality improvement be documented across programs over time?
- Can the impact of newly established disease state management programs be evaluated?
- Can small-scale programs piloted for special need populations be expanded to enroll larger numbers?
- How is member satisfaction affected by instability in provider networks and plan participation?

The opportunity for savings from managed care, according to Dr. Hurley, has been constrained by the lower payment base for Medicaid; basically, the savings achieved in the commercial sector are not relevant for a program that was already paying "bargain basement" rates. Credible research suggests that savings in the early Medicaid managed care programs ranged from 5%-15%. It is less clear today if managed care produces savings, partly because costs are rising for everyone. Also, the potential for savings are limited by the fact that the large number of enrollees in Medicaid managed care plans are responsible for only a small portion of Medicaid's overall costs.

The research suggests that the states' competence in managed care has improved dramatically over time, especially in terms of contracting. Many Medicaid agencies have determined that they can extract more accountability by contracting with health plans than by contracting with individual providers. They have also instituted systematic and consistent performance monitoring using HEDIS or state-developed indicators.

Several timely questions that need to be resolved include:

- Are cost savings real and sustainable over time?
- Are cost savings for chronically ill and disabled beneficiaries attainable and desirable?
- Will states be able to meet the financial requirements of prepaid health plans in the future?
- Will states sustain the level of effort invested in developing managed care programs if substantial savings are not achievable?

TEACHING AND LEARNING WITH VULNERABLE POPULATIONS

In the mid-1980s, Dorothy L. Powell, EdD, RN, FAAN, associate dean for nursing at the College of Pharmacy, Nursing, and Allied Health Sciences at Howard University, received a grant from the Kellogg Foundation to partner with the Community for Creative Non-Violence (CCNV) in Washington, DC, to create a nurse-managed clinic for the homeless. In her plenary presentation, “Teaching and Learning While Caring for Vulnerable Populations,” Dr. Powell discussed her experiences in developing a new curriculum for nursing students built around providing care for a vulnerable population in a community setting.

To set the context, Dr. Powell argued that clinicians cannot provide good care until they learn to ask three critical questions: Who are these people? What do they need? Where are they coming from?

The needs of vulnerable populations are not necessarily well matched with a traditional managed care model. This requires adjustment when designing managed care programs for Medicaid recipients. For example:

- While managed care focuses on health promotion and prevention, the focus for vulnerable groups tends to be on illness and acute care.
- The complex problems of vulnerable populations push the borders of managed care protocols and require more time than managed care allows.
- The complex system of referrals in a managed care system does not work for a population that lacks access to the transportation needed to move around from place to place.
- The gatekeeper system does not sit well with people who have a basic distrust of the health system—a distrust that is compounded by the experience of being sent away by the gatekeeper to get care elsewhere.
- The budgetary constraints of a managed care environment are at odds with the expensive health care needs of vulnerable groups.

Dr. Powell and her students had to rid themselves of stereotypical perceptions of homeless people and recognize them as individuals with their own stories, priorities, and concerns. In particular, the students and their teachers learned to show respect for people by asking them what their needs are rather than deciding for them. In addition, Dr. Powell learned that the traditional beliefs and practices of an “ivory tower” institution are not easily altered. Most faculty were reluctant to participate and did not welcome this change in the curriculum. Students, on the other hand, tended to be more receptive and enthusiastic, which eventually helped to convince some of the faculty to change their views.

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Looking back on her experience, Dr. Powell advised others to do the following:

- seek input from the targeted community,
- focus on collaborating with community-based organizations,
- welcome other disciplines,
- sensitize the faculty, and
- seek buy-in from academic administrators.

Dr. Powell also encouraged teachers to expose students early to vulnerable populations for socialization and assessment, and to give them ample opportunity to process their observations and perceptions and share their experiences.

As a result of the program, according to Dr. Powell, a core body of knowledge about vulnerable populations had to be incorporated into the curriculum for undergraduate and graduate students. This knowledge was expanded by contributions from faculty as well as homeless individuals that participated in communicating their needs. Strands of this new material were deliberately integrated throughout the curriculum; for example, students learned how standard duties like disease assessment and history taking may be different in the context of the homeless experience. Another outcome was that the boundaries of disciplines became blurred as the nursing school opened itself up to collaboration with many partners, some less traditional than others.

On a personal level, the experience with CCNV enhanced the students' sensitivity, multicultural tolerance, and respect for others and reduced their reliance on stereotypes of the homeless population. It also gave them a better sense of their own beliefs and values. On a professional level, the experience has also supported the students in problem-based learning. It gave them a better appreciation for comprehensiveness in care, taught them to communicate and listen effectively, and made them more flexible and adaptable.

LESSONS FROM IMPLEMENTATION AND CHALLENGES FOR THE FUTURE IN MEDICAID MANAGED CARE

Take away lessons from the conference included an understanding that as Medicaid expands the managed care model to more segments of the population, it has to heed lessons learned by states over the past several years. According to Dr. Rowland:

- Implementation takes time and planning.
- Programs have to make sure that beneficiaries are matched with the right plan for their needs and are given information useful for making enrollment decisions.
- Adequacy of payment rates are key to assuring plan participation and stability.
- Oversight and monitoring are essential.

While Medicaid managed care has demonstrated the potential for improving access, all the presenters concluded that it has yet to achieve this goal, especially for medically under-served communities. Dr. Rowland summed up the challenges for the future in this way:

- Developing broader networks of services to meet the needs of vulnerable populations. In particular, Medicaid managed care programs will have to address their inexperience with elderly and disabled populations and develop models for tailoring delivery systems in order to serve the segments with higher costs and greater health needs more effectively and efficiently.
- Despite a wealth of case studies, a national picture does not exist of which programs work, which do not, and why. Moreover, why a program succeeds in one state and fails in another is also not known.
- While managed care has the potential to make spending more predictable, states must come to terms with the limited potential for savings.
- Finally, the biggest challenge may lie in balancing all of these and other demands in the face of growing fiscal pressures associated with the current recession—pressures that will only be exacerbated as unemployment and the ranks of the uninsured grow.

FINALLY, THE BIGGEST CHALLENGE MAY LIE IN BALANCING ALL OF THESE AND OTHER DEMANDS IN THE FACE OF GROWING FISCAL PRESSURES ASSOCIATED WITH THE CURRENT RECESSION—PRESSURES THAT WILL ONLY BE EXACERBATED AS UNEMPLOYMENT AND THE RANKS OF THE UNINSURED GROW.

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Partnerships for Quality Education

Partnerships for Quality Education (PQE) was launched in 1996 with a grant from The Pew Charitable Trusts. Guided by Pew's vision of better preparing primary care residents for practice in the evolving world of health care, PQE used its resources to foster collaboration between academic medical centers and managed care organizations. Between 1996 and 1999, PQE funded 66 partnerships to develop new curricula and new models for training clinicians in the skills and competencies of managing care. In 1999, The Robert Wood Johnson Foundation (RWJF) awarded PQE a grant to continue its work in developing new models for education in managing care. In addition to its work with residency programs, PQE expanded its focus to include the education of nurse practitioner students, and to support the design of new approaches to preparing trainees for collaborative interprofessional practice.

Tufts Managed Care Institute

Tufts Managed Care Institute is an independent, not-for-profit educational organization established in 1995 as a collaborative venture of Tufts University School of Medicine and Tufts Health Plan. The Institute's mission is to help physicians and other health care professionals—at all stages of their training and development—to practice comfortably and effectively in a high quality, cost-effective, managed health care system. The Institute provides managed care education through the development, implementation, and dissemination of tools, resources, and curricula. TMCI creates offerings that are compelling, responsive to regulatory requirements, designed to produce measurable impact, and created with the learner's context in mind. TMCI has reached thousands of health care professionals with its educational programs—in the classroom, online, and through enduring materials.

Conference Materials

Conference materials, such as the complete proceedings, the conference course book with plenary presentation slides, articles, and a comprehensive Medicaid managed care bibliography, including diskette with online Medicaid managed care resources, is available through **www.tmci.org** or by calling Tufts Managed Care Institute at 617-636-1000.

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