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## RESOURCE PAPER

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### **State Medicaid Managed Care Evaluations and Reports Themes, Variations, and Lessons**

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261

## **TABLE OF CONTENTS**

Executive Summary _____	2
Introduction _____	7
Notable Features of Each State’s Approach and Context _____	9
Themes, Variations, and Lessons _____	13
Theme 1: Performance Measurement, Good Data, and Public Accountability _____	13
Theme 2: Public Reporting of Individual Plan Performance _____	14
Theme 3: Different Audiences with Varied Interests and Needs _____	16
Theme 4: Packaging the Message _____	19
Theme 5: Highlighting Problems and Challenges, Not Just Successes _____	20
Theme 6: Limited Resources as a Barrier _____	21
Theme 7: Focusing on Current Concerns and Fixable Problems _____	23
Theme 8: Internal Value of Evaluation _____	25
Theme 9: “Awake at the Wheel” – Evaluation as Credibility Enhancement _____	26
Theme 10: Linking Internal Quality Improvement Efforts and External Reporting _____	27
Conclusion _____	28

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## EXECUTIVE SUMMARY

State Medicaid managed care programs cover over 57 percent of the more than 40 million people enrolled in Medicaid and account for a significant share of total state spending. In contracting with managed care organizations (MCOs) and physicians to provide care to Medicaid beneficiaries, states seek to ensure that taxpayer dollars are being spent as effectively as possible.

States have undertaken a wide range of efforts to evaluate and report on their Medicaid managed care programs to help ensure that public dollars are being put to good use and that Medicaid beneficiaries are receiving high-quality, efficiently administered care. We look at how four states—Arizona, Maryland, Rhode Island, and Virginia—have carried out this responsibility, and draw lessons for other states from their experiences. We highlight lessons that focus on identifying audiences and tailoring evaluations and reports to those audiences' interests and needs.

### Notable Features of Each State's Approach and Context

The four states vary substantially in the size, scope, and history of their Medicaid managed care programs, the contexts in which the programs operate, and the resources available for evaluation and reporting.

- Arizona operates the oldest (begun in 1982) and most comprehensive capitated Medicaid managed care program in the country and has a large and analytically sophisticated staff, but does relatively little public reporting, reflecting in large measure the limited demand for such information from the legislature and other stakeholders.
- Maryland's mandatory capitated managed care program is more recent, less well established, and less comprehensive than Arizona's (it does not cover long-term care), and it has been subject to intense public scrutiny and considerable controversy since its inception in 1997. Maryland has very substantial analytic and data resources, which enabled the state to produce a comprehensive and well-publicized evaluation of its managed care program in 2001.
- Rhode Island's capitated mandatory program began in 1994, and is less comprehensive than Arizona's and Maryland's, since it covers neither disabled populations nor long-term care. The program has experienced little controversy, reflecting in part the extensive evaluation, public reporting, and program improvement efforts the Medicaid agency has undertaken since the outset of the program, using a combination of well-developed internal and external resources.

- Virginia’s mandatory capitated managed care program began in 1996 and operates primarily in the more urban areas of the state. It is similar in scope to Rhode Island’s, and also has experienced relatively little controversy. The program began substantial and well-received evaluation and public reporting efforts in 2001; they have been conducted primarily by a small internal staff using the types of information that are routinely available in most states.

## Lessons

Since we deliberately chose states for our case studies that had taken different approaches to evaluation and reporting there was considerable variation among the four states, but a number of common themes and lessons emerged. The lessons and some of the variations are summarized below.

**Lesson 1: Performance measurement is a threshold requirement for Medicaid managed care purchasers, but the demand for and impact of these measures can vary over time and with the state context.**

While all the case study states collect and use a wide variety of data and reports in their Medicaid managed care programs (encounter data, HEDIS and CAHPS measures, EQRO reports, and reports on enrollment and disenrollment, complaints and grievances, provider participation, and MCO finances<sup>1</sup>), Arizona and Maryland have made especially good use of encounter data, Maryland and Rhode Island have used consumer focus groups, and Rhode Island has made creative use of public health data, including birth records.

Good data can sometimes create its own demand. Rhode Island and Maryland have developed wide audiences for their data and reports, while external audiences in Arizona appear less interested. Virginia is an intermediate case; its data capabilities are more limited than those of the other case study states, but its major recent efforts to reach external audiences have been quite successful.

**Lesson 2: The benefits of public reporting of individual plan performance are greatest when external audiences are interested, plans feel pressure to improve, and the data are credible.**

Although Medicaid consumers generally make little use of health plan performance data to choose among plans,<sup>2</sup> health plans pay close attention to these performance measures, especially when there is competition among plans, state officials use the measures for

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<sup>1</sup> Encounter data are records of health service utilization and costs based on provider “encounters” with MCO enrollees. HEDIS is the Health Plan Employer Data and Information Set, developed by the National Committee for Quality Assurance. CAHPS is the Consumer Assessment of Health Plans Survey, developed by the Agency for Healthcare Research and Quality. EQROs are External Quality Review Organizations.

<sup>2</sup> Verdier J., Dodge R., Chimento L., Menges J., and Forbes M. *Using Data Strategically in Medicaid Managed Care*. Center for Health Care Strategies, January 2002.

decision making, and the data are publicly reported with plan names attached. Plans expressed concerns about public reporting of health plan financial data, since they believe it can be misinterpreted, but are more comfortable with public reporting of data on access and quality, such as HEDIS and CAHPS measures, as long as they are confident that the data are reasonably complete and accurate.

Arizona and Rhode Island generally do not attach plan names to publicly reported health plan performance measures, preferring to report on the performance of the managed care program as a whole. Maryland is now developing a plan-specific report card, and Virginia has included plan-specific performance measures in its 2002 and 2003 managed care performance reports.

**Lesson 3: Data and performance measurement systems must address the concerns of diverse audiences and should be developed with a full appreciation of the perspectives and needs of those audiences.**

The audiences for Medicaid managed care reports and evaluations include:

- Health plans, which pay special attention to publicly reported measures that compare their performance to other plans operating in the same marketplace or state and to national benchmarks.
- Legislators, who generally have little interest in overall Medicaid managed care issues unless they are on legislative budget or health committees, but who may have narrow and episodic interests prompted by complaints from individual providers, constituents, or organized groups.
- Consumers, who want ready access to good-quality care, but rarely rely on public reports or evaluations to make decisions about enrollment in health plans.
- Providers, who are primarily interested in prompt payment and low administrative burdens and are likely to be attentive to reports on those issues.
- The media, who are mainly interested in problems and controversy stimulated by complaints related to individual beneficiaries and providers, but who may be interested in broader performance data that put individual anecdotes in context and provide some of the other side of the story.

**Lesson 4: It is essential to think how best to present data and performance measures from various audiences' points of view.**

All of the case study states have struggled to find effective ways of “packaging the message” for different audiences. Virginia’s managed care performance reports have been notably successful in presenting readily available information in ways that tell a clear and compelling story, but even those reports have had to be distilled into a more concise

form for use with legislators. Arizona has developed a relatively short slide presentation (known informally as “AHCCCS 101”) for use with legislators.<sup>3</sup>

Health plan report cards based on HEDIS and CAHPS measures are generally designed for public use, and can have a significant impact on health plans and, to a lesser extent, consumers, legislators, and the media. Major reports on or evaluations of a state’s Medicaid managed care program may generate media coverage if the agency packages them effectively, or if they address ongoing controversies or major concerns.

**Lesson 5: Acknowledging problems and proposing ways to fix them builds credibility and trust.**

All of the case study states viewed their reports and evaluations as ways of identifying problems and improving their programs, not just as vehicles for success stories. They acknowledge problems forthrightly and report them promptly. This approach enhances the Medicaid agency’s credibility with the legislature and other stakeholders and observers.

**Lesson 6: Do as much as you can with what you have, and supplement that to the extent possible with outside expertise.**

AHCCCS, the Arizona Medicaid agency, has a large and analytically sophisticated staff and well-developed encounter data, but has devoted relatively little effort until recently to using its data for evaluation and external reporting purposes. The Maryland Medicaid agency has a substantial internal analytic staff and a long-standing relationship with a local university that gives the state access to a dedicated staff of data analysts and researchers, which enabled the agency to prepare the comprehensive 2001 evaluation of its managed care program largely with internal resources. The Rhode Island Medicaid program has made the most extensive and creative use of both internal and external analytic resources among our case study states, using a combination of internal staff, long-standing external contractors, other state agencies, foundation grants, and local university researchers to produce an extensive series of evaluations and reports stretching over the last decade. Virginia has the most limited data and analytic resources among our case study states, but has made successful use of available resources in a series of managed care performance reports published in 2002 and 2003.

**Lesson 7: Evaluations should focus on current problems and unanswered questions; standard regular reports can cover the basics of ongoing program operations and detail past successes.**

Reports and evaluations have their greatest impact when they focus on issues of major concern to stakeholders, and when they address important problems that need fixing. Routine tracking reports (enrollment and disenrollment trends, monthly expenditures,

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<sup>3</sup> The Arizona Medicaid program and the agency that administers it are called the Arizona Health Care Cost Containment System, or AHCCCS.

complaints and grievances) can provide a valuable underpinning for ongoing program evaluation efforts, but may not be especially illuminating if trends have stabilized and differences among plans are minimal. Analytic resources are always limited, so states should focus them on high-priority problem solving.

**Lesson 8: Medicaid agencies are usually more concerned about managed care performance and quality than most outside audiences and have a compelling need to know if their programs are working.**

While the Medicaid agencies in our case study states were generally attentive to the needs and interests of external stakeholders, they all said that some of the most important impacts of their reporting and evaluation efforts were internal. As one top official put it, “the number one audience is us.” One important reason is that state officials and staff are among the few people for whom caring about the Medicaid managed care program is a full-time job. Another is that agency officials are the people most likely to be on the “hot seat” in supporting or defending the program, and thus need solid evidence on its impact.

**Lesson 9: The price of freedom is proven performance.**

Our case study states found that demonstrating to legislators, the federal Centers for Medicare and Medicaid Services (CMS), and other stakeholders that the Medicaid agency is sensitive to their concerns and operating the program effectively enables the agency to be relatively free from micromanagement.

**Lesson 10: Focus on fixing things people care about and make sure they know you are working on their problems.**

As Medicaid agencies pursue internal quality improvement efforts, both within the agency and in partnership with health plans, they should be alert for opportunities to highlight their efforts for external audiences.

## **Conclusion**

Measuring managed care performance is not optional. What aspects of performance to focus on, how to report on it, and to whom can vary with the state context, resources, and program needs, but collection and use of performance data is critical to program improvement, accountability, and credibility.

## INTRODUCTION

State Medicaid managed care programs covered more than 57 percent of the more than 40 million people enrolled in Medicaid nationwide in mid-2002.<sup>4</sup> Medicaid as a whole accounted for nearly 21 percent of total state spending in that year.<sup>5</sup> Medicaid managed care programs thus have a major impact on the health care received by a significant portion of the nation's population as well as on the budgets of almost all states (only 14 states had fewer than half of their Medicaid beneficiaries enrolled in managed care in 2002).

In these managed care programs, states enter into contracts with either managed care organizations (MCOs) or physicians (in primary care case management [PCCM] programs) to provide or arrange care for Medicaid beneficiaries. In their role as purchasers of health care, states seek to ensure that the value of that care, both to Medicaid beneficiaries and the state's taxpayers, justifies the taxpayer dollars that are spent on it.

Measuring the value of health care services is highly complex and uncertain, and the available measures are inevitably imperfect. But leaving such a large portion of a state's business unexamined and unmeasured is not an option. Public accountability requires that those who are responsible for Medicaid managed care programs make the best possible efforts to measure the value of what they are purchasing and report the results of those assessments to taxpayers and their elected representatives.

Although states are required by the federal government to arrange for external evaluations of their managed care programs to help inform the federal decision on whether to continue the "waivers" that authorize the programs, these evaluations have often not been rigorously done, operationally meaningful to states, or timely, and have generally not been widely circulated.<sup>6</sup>

In this report, we examine how four states – Arizona, Maryland, Rhode Island, and Virginia – have assumed direct responsibility for evaluating and reporting on their Medicaid managed care programs.<sup>7</sup> These case study states have adopted different approaches, depending on the history and evolution of their programs; the changing political environment; health care marketplace forces; state resources for data collection,

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<sup>4</sup> Centers for Medicare & Medicaid Services, "2002 Medicaid Managed Care Enrollment Report." Available on the Web at: <http://cms.hhs.gov/medicaid/managedcare/immcss02.asp> [Accessed January 16, 2004].

<sup>5</sup> National Governors Association and National Association of State Budget Officers, "The Fiscal Survey of States," December 2003, p. 1. Available on the Web at <http://www.nasbo.org/Publications/fiscsurv/fsfall2003.pdf> [Accessed January 16, 2004].

<sup>6</sup> New federal regulations that modify the requirements for external quality review of Medicaid managed care organizations may result in more useful assessments of quality-related aspects of Medicaid managed care programs, but the impact of these new regulations will not be fully clear for some time. The new regulations appear in the January 24, 2003 *Federal Register*, Vol. 68, No. 16, pp. 3586-3638, and in 42 CFR sec. 438.310-370.

<sup>7</sup> Many other states conduct similar activities. While we reviewed a number of other states before deciding on these four illustrative case study states, we did not conduct a comprehensive review of evaluation and reporting efforts in all states.

analysis, and reporting; and the interest of various audiences in the managed care programs.

For each of the four states in our study, we reviewed a wide range of the reports they have prepared on their Medicaid managed care programs and interviewed by telephone state Medicaid managed care officials, Medicaid MCO representatives, state legislators and staff, and consumer representatives. We promised the interviewees anonymity if they wished, and gave them the opportunity to review draft portions of this report that pertained to their states. We conducted approximately five interviews per state from September through November 2003.

The main questions we asked were:

- What was the impetus for the various evaluations and reports you prepared?
- Who are the intended audiences?
- What resources are needed to prepare the evaluations and reports?
- What major issues and topics are covered?
- What impacts have the evaluations and reports had?
- What lessons have you learned that would be helpful for other states?

A number of common themes emerged from our research and interviews, along with significant variations among the four case study states. The variation was not an accident; we deliberately chose states that had taken different approaches to evaluating and reporting on their Medicaid managed care programs. With a goal of identifying a range of approaches and practices that other states could emulate, we sought states that reflected as much as possible the diversity that characterizes state Medicaid managed care programs.

We have tried to distill lessons for other states from the common themes and variations that emerged from our research. We highlight lessons that focus on identifying audiences and tailoring evaluations and reports to those audiences' interests and needs. Audiences may include governors, legislators, state agency managers and staff, health plans, health care providers, consumers, media, the business community, and other stakeholders. Because we have discussed elsewhere in detail the kinds of data Medicaid managed care programs can collect and report, and how the data can best be presented, we do not address those issues in depth in this report.<sup>8</sup>

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<sup>8</sup> Verdier, et al., op.cit.

## NOTABLE FEATURES OF EACH STATE'S APPROACH AND CONTEXT

As previously mentioned, the approaches taken by our case study states in preparing evaluations and reports on their Medicaid managed care programs vary widely. As background for our discussion of common themes, variations, and lessons, this section provides a brief overview of the approach to reporting and evaluation taken by each of the states and identifies some major features of the context in which the state Medicaid agency operates.

### Arizona

The Arizona Health Care Cost Containment System (AHCCCS) is the oldest mandatory Medicaid managed care program in the country and enrolls all beneficiaries in prepaid health plans. It started in 1982 and operates statewide, covering both acute and long-term care for the state's entire Medicaid population. AHCCCS had 739,000 enrollees in mid-2002, 94 percent of whom were in risk-based managed care.<sup>9</sup> AHCCCS employs a staff of more than 1,300 and, unlike most state Medicaid agencies, operates as a separate stand-alone agency. As of 2002, nine acute care MCOs served the Medicaid population in various parts of the state. All but one of the plans was Medicaid-only. (Additional health plans provide long-term care and behavioral health services.)

Since AHCCCS has operated from the outset as a federal "research and demonstration" program under a section 1115 waiver, there were several extensive federally required external evaluations throughout the 1980s and into the mid-1990s. As the program became more stable and firmly established, the impetus for full-scale comprehensive evaluations waned. Reports and evaluations became more narrowly targeted, focusing on specific aspects of the program of concern to legislators and others, such as immunizations. While the agency continued to gather and report encounter and other data on all aspects of the program and to make extensive use of the data for internal management purposes, it made relatively little effort to tell external audiences in the legislature and elsewhere "the story" of the AHCCCS program and its accomplishments.

Nonetheless, the legislature and others came to view AHCCCS as highly competent, accountable, and responsive, allowing the agency to operate without extensive external scrutiny. Apart from key members of legislative budget and health committees, few members paid much attention to AHCCCS, while consumers and the general public viewed it with generally benign inattention. Major stakeholders such as hospitals, health plans, community health centers, and groups that advocate for AHCCCS beneficiaries do watch AHCCCS carefully, however, and track program data. AHCCCS has well-established working relationships with the health plans it contracts with, most of which focus primarily on the Medicaid population and have been with the program for many years.

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<sup>9</sup> CMS, "2002 Medicaid Managed Care Enrollment Report."

With a new governor in 2003, significant turnover in the legislature as a result of term limits and other factors (about 40 percent of members are new in each session, we were told), and major state budget problems,<sup>10</sup> AHCCCS is under increasing pressure to explain and justify its work and to demonstrate that it is producing value commensurate with program costs.

## **Maryland**

Maryland had 656,000 Medicaid enrollees in mid-2002, about 69 percent of whom were enrolled in risk-based managed care programs.<sup>11</sup> In addition to a small internal analytic staff, the Medicaid agency has had a long-standing contractual relationship with the University of Maryland-Baltimore County (UMBC) for assistance with data, policy, and program analysis. Six MCOs served the state's Medicaid population in 2002, all of which were Medicaid-only.

Like Arizona, Maryland has had a long history of Medicaid managed care, with more than 20 years of experience in contracting with MCOs to serve beneficiaries. The state also initiated a mandatory PCCM program in the early 1990s for beneficiaries not enrolled in MCOs. Until 1997, however, enrollment in MCOs had always been voluntary. In 1997, Maryland instituted a new mandatory risk-based program under a section 1115 waiver, covering all beneficiaries not enrolled in institutions, including chronically ill and disabled beneficiaries. Unlike Arizona, however, the Maryland managed care program covers only acute care services, not long-term care. In addition, capitated managed care does not include most behavioral health services.

The new mandatory managed care program was highly visible from the outset, with a wide range of stakeholders involved in initial program design and development. The stakeholders were concerned about a host of issues, concerns that were reinforced by the rapid implementation of the new program. The program experienced some well-publicized rate-setting problems in 1999 when plans appeared to be overpaid because of technical errors, further adding to the program's visibility and generating more controversy. As the program developed, rate negotiations with MCOs remained tense, accompanied by threatened and actual MCO withdrawals. Significant pockets of consumer and provider opposition to the program persisted. And unlike Arizona, the Maryland legislature (which is not term-limited) has historically paid close attention to the Medicaid program, and Medicaid consumer groups are well organized and active.

In fall 2000, with concerns about the managed care program continuing unabated, top leaders in the Medicaid agency knew that the program had to prove its value if it was to continue in its current form. Accordingly, they decided to undertake a major and

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<sup>10</sup> For fiscal year 2005, Arizona's budget deficit was projected in late 2003 to be \$800 million to \$1 billion, 13 to 16 percent of the state's total general fund. Johnson N. "Projected State Budget Deficits for Fiscal Year 2005 Continue to Threaten Public Services." Center on Budget and Policy Priorities, December 22, 2003.

<sup>11</sup> CMS, "2002 Medicaid Managed Care Enrollment Report."

comprehensive evaluation of the program, and to do it in a highly visible and participatory way. The story of that 2001 evaluation is recounted in detail in a recently published article in *The Milbank Quarterly*, and key aspects of the Maryland experience are highlighted throughout this report.<sup>12</sup>

## Rhode Island

The Rhode Island Medicaid program had 172,000 enrollees in mid-2002, 68 percent of whom were in risk-based managed care.<sup>13</sup> The managed care program – called RIte Care – also was launched under the auspices of a section 1115 waiver. It covers only families and children, not the chronically ill and disabled, and only acute care services, not long-term care.<sup>14</sup> The managed care program has a small in-house staff of state employees, but has supplemented that staff with highly experienced consultants and evaluators who work in the same offices as the state staff and perform extensive program monitoring, reporting, and evaluation work. In addition, the Medicaid agency has developed collaborative relationships with other state agencies and with Brown University to supplement further the agency's evaluation capabilities.<sup>15</sup> As of 2002, three commercial MCOs served the state's Medicaid population.

The RIte Care managed care program began operations in 1994, and has experienced little of the kind of controversy experienced by the Maryland program in the late 1990s. From the outset, key managers in the program fostered a “culture of evaluation” in which program managers, staff, and consultants continually examined the program to identify problems and areas for improvement. The resulting reports are aimed at both internal and external audiences. Consumer advocates, who are well organized and active in Rhode Island, are heavily involved in these evaluations. While the state has a fairly collaborative relationship with the MCOs that serve RIte Care members, the MCOs have not played an extensive role in the evaluations, beyond submitting encounter data.

Apparently reflecting a perception that the program is well run and does not have major financial or other problems, the legislature does not involve itself extensively in the RIte Care program. Although Rhode Island has not undertaken a full-scale comprehensive evaluation of the program, it conducts a wide range of ad hoc evaluations and reports on specific issues and prepares a thorough and readable annual report on RIte Care and its accomplishments.<sup>16</sup>

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<sup>12</sup> Chang D., Burton A., O'Brien J., and Hurley R. “Honesty as Good Policy: Evaluating Maryland's Medicaid Managed Care Program,” *The Milbank Quarterly*, Vol. 81, No. 3, 2003, pp. 389-414.

<sup>13</sup> CMS, “2002 Medicaid Managed Care Enrollment Report.”

<sup>14</sup> RIte Care began voluntarily enrolling children with special health care needs into one of the Medicaid MCOs in September 2003.

<sup>15</sup> For additional detail on Rhode Island's approach to research and evaluation, see Sharon Silow-Carroll, “Building Quality into RIte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations.” *The Commonwealth Fund*, January 2003, especially pp. 15-21.

<sup>16</sup> For the most recent annual report, see Rhode Island Department of Human Services, “Rhode Island Medicaid Program, Annual Report, Fiscal Year 2002.” Available on the Web at [http://www.dhs.state.ri.us/dhs/reports/MA\\_AnnualReport\\_2002.pdf](http://www.dhs.state.ri.us/dhs/reports/MA_AnnualReport_2002.pdf) [Accessed January 6, 2004]. For a recent example of Rhode Island's data analysis and evaluation initiatives, see Griffin J., “Health Indicator System for Rhode Islanders

## Virginia

Virginia had nearly 497,000 Medicaid enrollees in mid-2002, 65 percent of whom were enrolled in managed care.<sup>17</sup> Of the managed care enrollees, 238,000 (77 percent) were enrolled in MCOs and another 72,000 (23 percent) in the state's PCCM program, which operates primarily in rural areas. Virginia includes most Medicaid populations in managed care, including those eligible through the Supplemental Security Income (SSI) program. As in Maryland and Rhode Island, managed care covers only acute care services, not long-term care. The managed care program has a small internal state staff that is responsible for program monitoring and reporting. As of 2002, seven MCOs participated in the state's Medicaid program, one of which was Medicaid-only and the rest commercial.

The PCCM program began on a pilot basis in 1992 and expanded statewide in 1995. The mandatory MCO program began in 1996 and has gradually expanded to cover most of the more heavily populated areas of the state. The MCO program operates side-by-side with the PCCM program in about one-quarter of the state, and beneficiaries can enroll in either program in those areas.

During the 1990s, the managed care program provided regular progress reports to the legislature and others on the implementation of the program, but the reports consisted primarily of tables of data on enrollment trends and expenditures. Some external evaluations and surveys were undertaken to comply with federal waiver requirements, but were not widely circulated. In 2001, following their attendance at a Center for Health Care Strategies Purchasing Institute on managed care performance reporting, the Medicaid agency staff decided to develop a new report on the managed care program, primarily to help inform newly arrived top management within the agency. The staff started with a basic report in January 2002 on MCO quality activities, followed by an overview of Medicaid managed care in May 2002 and a six-page Medicaid managed care performance report in July 2002.<sup>18</sup> The July 2002 report was followed by a more extensive performance report in November 2002. The various reports quickly gained an audience outside the agency, especially among MCOs, some legislators and staff, and reporters. The November 2002 report also drew some national attention.<sup>19</sup> In November 2003, the agency produced a fuller and more polished version of the managed care performance report, which covered the 2002-2003 state fiscal year.<sup>20</sup>

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on Medicaid: An Effective Model to Identify Unmet Health Care Needs and Evaluate Program Initiatives." Center for Health Care Strategies, forthcoming.

<sup>17</sup> CMS, "2002 Medicaid Managed Care Report."

<sup>18</sup> These reports are posted on the Virginia Department of Medical Assistance Services Web site at <http://www.dmas.state.va.us/mc-home.htm> [Accessed January 2, 2004]. See "Quality Assessment Study, January 2002," "Overview of Managed Care," and "Medicaid Managed Care Performance Report, July 2002."

<sup>19</sup> Goodman J., "Virginia's Medicaid Data Gets a Makeover," *Governing Magazine*, October 2003; "Va. Readies New Data for Medicaid MCOs, as Sentara, Anthem Report DM Gains," *News and Strategies for Managed Medicare & Medicaid*, Vol. 9, No. 17, Atlantic Information Services, October 2003, pp. 1-4.

<sup>20</sup> Available at [http://www.dmas.state.va.us/downloads/pdfs/mc-annual\\_report\\_2003.pdf](http://www.dmas.state.va.us/downloads/pdfs/mc-annual_report_2003.pdf) [Accessed January 2, 2004].

MCOs and the state used the November 2002 report to help obtain funding for MCO rate increases in the 2004 budget that were greater than the legislature had first proposed. While consumer advocates are generally aware of the performance reports, they focus primarily on the specific concerns of individual consumers. And given that consumers and advocates generally view the Virginia Medicaid managed care program positively, they do not appear to need the broader evidence included in the performance reports to be convinced of the program's value. The MCOs, by contrast, told us that they appreciate the state's compilation and presentation of the evidence, as it helps garner legislative support.

## **THEMES, VARIATIONS, AND LESSONS**

In this section, we present the themes that have emerged from our research and interviews, with variations from each of our case study states. We also summarize under each theme the lessons we and our interviewees have drawn from their experiences.

### **THEME 1: Performance Measurement, Good Data, and Public Accountability**

All four case study states collect and use a wide variety of data and reports in their Medicaid managed care programs, including encounter data; data on complaints and grievances, enrollment and disenrollment, and provider participation; HEDIS and CAHPS measures; EQRO reports; and MCO financial reports.<sup>21</sup> Rhode Island also makes extensive use of public health data, including birth records, to measure the impact of its managed care program on prenatal care and intervals between births.

Arizona and Maryland are among the most advanced states in their development and use of encounter data for rate setting and program analysis. Rhode Island also has made good use of encounter data, while Virginia has made relatively little progress with their encounter data. States like Arizona and Maryland that have made extensive use of encounter data say that the data become more reliable and credible over time, especially when the data are used for rate setting, risk adjustment and public reporting, and that the availability of good encounter data can greatly increase a state's ability to monitor and report on managed care performance.<sup>22</sup>

All the states use these data sources to varying degrees to work with their health plans and hold them accountable for their performance. Recognizing that no single data source can tell a complete story about a plan's performance, the states look at a variety of sources to identify potential problems, and dimensions of performance that need improvement. The differences among plans on some measures may be small, and some

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<sup>21</sup> Encounter data are records of health service utilization and costs based on provider "encounters" with MCO enrollees. HEDIS is the Health Plan Employer Data and Information Set, developed by the National Committee for Quality Assurance. CAHPS is the Consumer Assessment of Health Plans Survey, developed by the Agency for Healthcare Research and Quality. EQROs are External Quality Review Organizations. The various ways in which states can and do use these data sources are discussed in Verdier, et al., *Using Data Strategically*.

<sup>22</sup> For a detailed discussion of encounter data, see Verdier, et al., *Using Data Strategically*, Chapter 2 ("Encounter Data: Opportunities and Challenges").

measures may fluctuate over time for reasons that have as much to do with the quality of the data as with actual performance. But if varying data sources combine to reinforce a common interpretation (high rates of complaints and disenrollments related to physician access, for example, combined with low CAHPS scores on access measures and declining provider participation rates), the case for intervention and corrective action is strengthened.

Maryland and Rhode Island have made extensive use of consumer focus groups in their program design and evaluation efforts. Focus groups can provide a human dimension to the data and analysis, and the information may be more timely and actionable than that obtained from claims and survey data. In addition, information from focus groups may sometimes prove more persuasive to legislators, reporters, and others who want to know what “real people” think about the program.

Within limits, good data can create its own demand. States like Rhode Island and Maryland that have devoted considerable effort to developing their data collection, analysis, and reporting capabilities and that have been aggressive in their reporting efforts have developed an audience for the data and an expectation that data will be available to address issues as they arise. Arizona has highly developed data and reporting capabilities, but external audiences’ perceived lack of interest has led the state to focus more of its efforts on working directly with health plans. Virginia is an intermediate case, combining relatively limited data capabilities with a major, recent effort to expand the audience for managed care performance measures.

**Lesson 1: Performance measurement is a threshold requirement for Medicaid managed care purchasers, but the demand for and impact of these measures can vary over time and with the state context.**

## **THEME 2: Public Reporting of Individual Plan Performance**

We found in our case studies that both states and plans were uneasy about public reporting of plan performance in the early stages of managed care programs, reflecting in large measure concerns that the data to measure performance were incomplete and potentially misleading, especially for new plans. As the data have improved, and states and plans have gained more experience in using plan performance comparisons for internal program monitoring purposes, the uneasiness about public reporting has diminished in at least some of the case study states.

All the case study states used plan-specific performance data for internal management purposes and for their work directly with the plans. The states varied, however, in the extent to which the data on individual plan performance were used publicly, and in the extent to which the state publicized performance measures for the managed care program as a whole rather than for individual plans.

Some states, such as Rhode Island, have been reluctant to make plan-specific data publicly available. They believe it can be more effective to work with plans collaboratively and behind the scenes to improve plan performance. In addition, Rhode Island has emphasized the performance and impact of the managed care program as a whole, across all plans, and thus has chosen to publicize most widely measures of RIte Care's impacts over time and as compared with commercially ensured populations.

The extent of public reporting of plan performance depends in part on external audiences' perceived interest in plan performance, which may be relatively low if plans are performing at relatively similar levels or the managed care program has not been especially visible or controversial. Furthermore, public reporting may not have a significant impact on plan performance if plans do not believe that they need to compete with each other on performance, as might be the case if the plans recognize that marketplace, political, or other conditions limit the state's contracting options.

### **Current Plan-Specific Reporting Initiatives**

Maryland is now developing a plan-specific report card, and health plan executives appear confident that it will be credible and useful. Virginia included plan-specific performance measures in its November 2002 managed care performance report, and provided even more plan-specific quality and access data in its November 2003 performance report. Rhode Island, as just noted, emphasizes the performance of the managed care program as a whole, and focuses less public attention on individual plan performance. Rhode Island does use comparative plan performance data to work privately with the plans to improve their performance. In addition, the Rhode Island Department of Insurance Web site lists 55 measures of plan performance for two of the state's three Medicaid plans covering finances, utilization, clinical measures, access, satisfaction and utilization review, including comparisons to state and national benchmarks.<sup>23</sup> In the past, Arizona has published the results of member satisfaction surveys but, in the most recent (2000) version, showed the results by county rather than by plan name.<sup>24</sup> State officials told us they had received little feedback or reaction regarding the results of these surveys from consumers, legislators, the media, or other stakeholders, but are now considering new efforts in this area.

### **Financial versus Access and Quality Measures**

Some of our interviews with plans indicated greater uneasiness about public reporting of financial data than about reporting of data on access and quality measures, such as those included in HEDIS and CAHPS.<sup>25</sup> Plans expressed concern that general audiences often

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<sup>23</sup> Office of Performance Measurement, "Rhode Island Medicare & Medicaid Health Plans Factbook, 2001," Rhode Island Department of Health, June 2003. Available on the Web at <http://www.health.ri.gov/chic/performance/medfactbook2001.pdf> [Accessed January 5, 2004].

<sup>24</sup> Arizona Health Care Cost Containment System, "Summary Report, Member Satisfaction Survey 2000."

<sup>25</sup> In Virginia, for example, financial performance data by plan were reported in the November 2002 managed care performance report with plan names attached to the measures. In response to plan concerns, the November 2003 report does not attach plan names to the financial performance measures, referring to the plans only as "MCO A,

did not fully understand financial data, and that the data could be misinterpreted and misrepresented. Further, health plans may not always use standard definitions when reporting financial measures such as administrative and medical cost ratios, and might not report financial data separately on their Medicaid line of business. Moreover, some measures such as medical cost ratios or profit may be subject to varied interpretation. These financial performance measures can have dual audiences with divergent interests and perspectives: investors and plan managers who are looking for signs of solid profitability and state agency officials, legislators, and members of the broader public who may view high profits as inappropriate in a publicly funded program.

HEDIS and CAHPS, by contrast, are designed for public reporting, and high scores on measures of access and quality are broadly viewed as positive and a goal to which all plans should aspire. When publicly reported, these measures can therefore be used to foster competition and motivate plans to improve. Plans may argue that HEDIS, CAHPS, and other access and quality measures are not complete measures of all dimensions of performance, that the data are old by the time they are reported, and that the data are often so highly aggregated that they do not provide the plan with useful guidance on appropriate improvement measures at the individual physician or practice level. Plans will rarely argue, however, that the data should not be publicly reported, if accompanied by appropriate caveats, and they generally respond to public reporting with efforts to improve their scores.

**Lesson 2: The benefits of public reporting of individual plan performance are greatest when external audiences are interested, plans feel pressure to improve, and the data are credible.**

### **THEME 3: Different Audiences with Varied Interests and Needs**

The audiences for Medicaid managed care reports and evaluations are quite diverse, and each has its own set of needs and perspectives. States should be aware of these differences and tailor their information and reports accordingly.

#### **Health Plans**

Health plans want to know how they are doing on a variety of performance measures. They pay special attention to publicly reported measures that compare them to other plans operating in the same marketplace or state. They also are interested in how they compare to national benchmarks, which is an important current gap identified by many study participants. They are interested both in trends in their own performance over time, and in comparisons to other plans at points in time.

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MCO B,” and so forth. The report notes that readers who want financial data for specific plans can obtain this information from the state Bureau of Insurance (Virginia Managed Care Performance Report, 2002-2003, p. 16).

## Legislators

Legislators generally have a limited set of interests with respect to Medicaid managed care, reflecting in part the wide scope of their overall responsibilities and the narrow and episodic way that Medicaid managed care issues generally come to their attention. Unless legislators receive complaints from individual providers, constituents, or organized groups, most of them have little reason to get involved in Medicaid managed care issues. Those serving on committees that deal specifically with Medicaid budget or policy issues are likely to have a greater continuing interest in Medicaid. In addition, if Medicaid is experiencing major budget problems, legislative interest is likely to be more widespread. Legislators are thus likely to be most interested in data on Medicaid budget issues and to have limited interest in overall data on access and quality. With the spread of term limits, a significant number of new legislators in each legislative session will likely have little or no familiarity with Medicaid managed care. States and health plans must therefore be prepared to provide “Medicaid 101” briefings and other information to these new legislators, but must recognize that new legislators are especially likely to be suffering from information overload, underscoring the importance of keeping it simple and brief – a guideline that applies to almost all information prepared for legislators.

## Consumers

Medicaid beneficiaries want ready access to good-quality care, but they rarely rely on public reports or evaluations to make decisions about enrollment in health plans.<sup>26</sup> They may have preferences for individual doctors, and preferences based on providers’ location, office hours, and the like, but they generally rely on their personal experiences and those of their family and friends – not health plan performance data – to make choices among physicians and health plans. Even organized consumer advocacy groups told us that they pay relatively little attention to HEDIS, CAHPS, and other quantitative measures of performance and access. Instead, they are more likely to rely on complaints from beneficiaries and providers to assess the performance of individual health plans and the state’s Medicaid managed care program. They appreciate state efforts to monitor managed care quality and access and enforce performance standards, but they may not have the resources to become directly engaged in these efforts. Among our case study states, consumer involvement in reporting and evaluation efforts was limited in Arizona and Virginia, while both Rhode Island and Maryland have made extensive efforts to involve consumers. In Rhode Island, for example, the RIte Care program has had an active Consumer Advisory Council since 1995, and the Evaluation Work Group obtains consumer perspectives from consumer representatives, focus groups, and consumer surveys. In Maryland, the Medicaid agency’s 2001 evaluation of the managed care program included 14 community forums around the state in which beneficiaries were invited to participate, 22 beneficiary focus groups, and meetings with consumer advocacy groups.

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<sup>26</sup> For a recent summary of the research on consumer use of reports and data on Medicaid managed care, see Dodge R., “What Kinds of Data Do Consumers Want and Use” in Verdier, et al., *Using Data Strategically*, Chapter 5.

## Providers

Physicians and other Medicaid managed care providers are primarily interested in prompt payment and low administrative burdens. Like consumers, they may appreciate state efforts to monitor and enforce health plan performance standards related to access and quality, but they are particularly interested in plan performance with respect to payment and administrative burden. Plans also note that state agency officials should, but do not always, recognize that plan-focused data requirements will at times increase providers' administrative burdens. In dealing with providers, therefore, states may want to emphasize what they are doing to improve plan performance on these latter dimensions. Provider satisfaction surveys also can be a good tool for states and health plans to use, both to identify problem areas and to signal that good relations with providers are a high priority.

## Media

Reporters, editors, and others in the media are mainly interested in problems and controversy. Good and steady health plan performance does not normally qualify as news. Press interest in Medicaid managed care is generally stimulated by complaints and problems related to individual beneficiaries and providers. In those cases, reporters will want information about those specific cases quickly and within their deadlines. Reporters also may be interested in broader performance data that put individual anecdotes in context and provide some of the other side of the story. The broader information may even be sufficient to persuade a reporter that a given problem is an isolated incident and thus not news. States and health plans should have broader contextual information readily available, such as consumer and provider satisfaction survey results and HEDIS and other utilization data, and be prepared to explain it concisely, persuasively, and within reporters' deadlines. A given problem or anecdote can present a "teachable moment" for reporters and the broader audiences they reach, but the opportunity can pass quickly if states and health plans are not ready to respond. Our state interviewees in Rhode Island and Virginia told us that continuing efforts to provide big-picture information to the press about their managed care programs were helpful in providing context and background when individual cases came up, even if the reports themselves did not generate press coverage when first released.

**Lesson 3. Data and performance measurement systems must address the concerns of diverse audiences and should be developed with a full appreciation of the perspectives and needs of those audiences.<sup>27</sup>**

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<sup>27</sup> For more detail on these issues, see Verdier J., *Implementing Medicaid Managed Care: Suggestions for Dealing with the Media, Legislators, Providers, Recipients, and Advocates*. Center for Health Care Strategies, November 1997.

## THEME 4: Packaging the Message

All of our case study states have struggled to find ways to present Medicaid managed care data to different audiences in ways that will capture the audiences' attention and respond to their needs.

### Legislators and Legislative Staff

The Virginia managed care performance reports have been notably successful in presenting readily available information in ways that tell a clear and compelling story about the managed care program's successes and challenges. Yet, health plan representatives, who used information from the reports to work with legislators to obtain additional funding for health plan rates, told us that they had to distill information from the reports into much more concise form for use with legislators.<sup>28</sup> Arizona publishes a voluminous report each year on its Medicaid program (*AHCCCS Overview*) but found that a relatively short slide presentation (known informally as "AHCCCS 101") was much more useful for legislators.<sup>29</sup> Interviewees in Rhode Island and Maryland also reported that few legislators read the in-depth evaluations that the Medicaid agencies produced on their managed care programs.

Nonetheless, legislators and legislative staff whom we interviewed emphasized that legislative staff on budget and health committees used and appreciated the more detailed reports and evaluations produced by state agencies. In particular, they looked for specific recommendations well anchored in program evaluations and comparisons with other states. Legislative staff stressed that the information they presented to legislators had to be concise and targeted; accordingly, they looked for tables, graphs, and short descriptions in these larger reports that could be easily highlighted for legislators. They also emphasized the importance of timely and relevant responses to individual legislators' requests. Legislators often extrapolate from these responses when making judgments about the overall capacity of the Medicaid agency.

### Health Plans

Technical staff and managers in health plans are accustomed to dealing with complex and detailed reports and evaluations and often want to see back-up detail in order to assess the validity of what is reported. For them, conciseness and good packaging is less important than it is for health plan CEOs and other top managers. For these higher-level managers, the performance of their plan on a few key dimensions—especially if their plan is compared to other plans—is highly relevant. The relevance is even greater if the

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<sup>28</sup> Health plan interviewees in Virginia pointed specifically to a bar graph on page 11 of the November 2002 managed care performance report that showed strikingly better recipient-to-provider ratios in risk-based managed care than in fee-for-service Medicaid. The graph, they said, clearly demonstrated to legislators that the managed care program afforded better access to physicians; therefore, they often distributed just that one graph.

<sup>29</sup> The "2003 AHCCCS Overview" report is available on the Web at: <http://www.ahcccs.state.az.us/Publications/overview/2003/contents.asp> [Accessed April 1, 2004]. The "AHCCCS 101" PowerPoint presentation is not on the agency Web site.

comparisons are made public or are used in decision-making by top officials in the Medicaid agency. As a result, public “report cards” on health plans that use measures such as HEDIS and CAHPS have a significant impact on the perceptions and behavior of top health plan management, in large part because of the efforts to make these measures user-friendly and standardize them in ways that facilitate comparisons among plans.

## **Consumers and Consumer Advocates**

Although our interviews and earlier research indicate that Medicaid beneficiaries and their advocates generally make only limited use of HEDIS, CAHPS, and other health plan performance measures when making choices among health plans, good packaging of these measures in public report cards can demonstrate to consumers and consumer advocates that the Medicaid agency takes seriously its responsibility to monitor and help improve health plan performance. “It’s one thing to say it,” a Virginia managed care official told us, “it’s another to show it.” In addition, as just noted, public reporting of health plan performance measures can have a direct impact on health plan behavior and the perceptions of other audiences, such as legislators and the media.

## **Media**

Under the right circumstances, the publication of a major report or an evaluation of a state’s Medicaid managed care program may itself provide the occasion for a newspaper or television story. For this to happen, however, the Medicaid agency will likely have to make major efforts to package the report, including preparation of a concise summary and press release and telephone phone calls to potentially interested reporters. The main question reporters and their editors will ask is “Why is this news?” If the report contains something new, surprising, and relevant to people’s lives, and is presented compellingly, it may be news; otherwise probably not.

**Lesson 4:** It is essential to think how best to present data and performance measures from various audiences’ points of view.

## **THEME 5: Highlighting Problems and Challenges, Not Just Successes**

While it is tempting to focus on managed care program successes, especially when the media and others tend to highlight problems, our case studies underscore the importance of acknowledging problems forthrightly and reporting them promptly.

Maryland state officials undertook their in-depth evaluation of the state’s Medicaid managed care program at a time when the program was under intense scrutiny and criticism. It was not clear to outside stakeholders or to the Medicaid agency itself that the program was meeting its goals. The agency determined that the best approach was to be as open as possible in conducting the evaluation, report fully and directly on any

shortcomings, and cast problems in the context of the overall program evaluation. Moreover, given that so many diverse interest groups were concerned about the potential impact of the program, the officials did not want each group's particular focus to divert attention from the bigger picture.

In Rhode Island, state officials say that a major goal of their studies and evaluations is “to look for what isn’t working right so we can fix it.” They use the evaluations to demonstrate to the legislature and other stakeholders that the agency is willing to change and wants to continue improving the program. Our interviews with legislative staff indicated that legislators appreciate this approach, and that it enhances the agency’s credibility.

The story we heard in Arizona was similar. AHCCCS staff stressed their commitment to continual improvement of the program; finding problems early and fixing them was important to that goal. The agency staff also emphasized the importance of being responsive and credible to the legislature; again, the staff tries to report and address problems as soon as possible and to respond promptly to problems raised by legislators. Our legislative interviews confirmed that the agency is viewed as highly competent, responsive, and on top of problems as soon as they are identified.

In Virginia, the legislature also viewed the Medicaid agency as responsive and open about problems. The initial managed care performance reports produced by the agency in 2002 stressed the positive aspects of the program, with only limited attention to problems and challenges. The balance shifted somewhat in the November 2003 report, which places more emphasis on remaining problem areas and future challenges. (“DMAS’s Internal Report Card recognizes the successes, near successes, and missed targets in the past year.”<sup>30</sup>)

**Lesson 5: Acknowledging problems and proposing ways to fix them builds credibility and trust.**

## **THEME 6: Limited Resources as a Barrier**

Despite limitations in staff and other resources that affect all Medicaid agencies to at least some extent, each of our case study states has demonstrated ingenuity and resourcefulness in reporting on and evaluating its managed care program.

### **Arizona**

AHCCCS, the Arizona Medicaid agency, employs a larger total staff (more than 1,300 people) than any other state Medicaid agency. However, only a small fraction of those people are available to work on data analysis, evaluation, and reporting. Furthermore, AHCCCS has focused on working directly with its health plans on performance issues rather than on systematically reporting on these issues to the legislature and other

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<sup>30</sup> Virginia Managed Care Performance Report, 2002-2003, p. 4.

stakeholders. Thus, while AHCCCS maintains extensive and highly sophisticated encounter data on service utilization and detailed health plan financial data, it has devoted relatively little effort to packaging the data for evaluation and external reporting purposes. With a new governor and substantial turnover in the state legislature, however, the agency is looking at new ways of presenting the information to be more responsive to emerging concerns.

## **Maryland**

Maryland also employs a sizable internal Medicaid agency staff and collects encounter data on health plan utilization that are comparable to the Arizona data. In addition, Maryland has a long-standing relationship with the University of Maryland-Baltimore County (UMBC) that gives the state access to a dedicated staff of data analysts and researchers who work, in effect, as extensions of the Medicaid agency staff. The UMBC staff played a significant role in the major internal evaluation of the Medicaid managed care program that Maryland conducted in 2001. Although using the UMBC staff for this year-long evaluation required diverting them from other ongoing Medicaid agency projects, the agency determined that these other projects had a lower priority during the evaluation period. Medicaid and UMBC staff worked closely and collaboratively in designing and conducting the evaluation and in modifying its scope as the project progressed and new issues arose. Agency staff underscored that the special relationship with UMBC provides them with the benefits of access to ready expertise, but with more flexibility than if they had to do a separate procurement to hire an outside evaluator.

## **Rhode Island**

Rhode Island has a small internal staff of state employees who work on managed care evaluation and reporting, but the agency has been highly entrepreneurial in obtaining other resources to supplement that staff. When the RIte Care program began in 1993, its state appropriation included a specific line item for evaluation, and that line item has been included in each subsequent appropriation. The Medicaid agency has used it to fund an independent evaluation consultant who works mainly out of an office in the agency. The Medicaid agency also was required by CMS as a condition of the original RIte Care section 1115 waiver to contract with an outside entity for monitoring and oversight of participating health plans, since CMS did not believe that the internal state staff was experienced enough at that time to perform these functions. That arrangement (with Birch & Davis/ACS) continues to this day. In addition, the Medicaid agency developed at the outset of the RIte Care program a relationship with the Department of Public Health that helped it to obtain important public health data relevant to the RIte Care program, such as birth records, and brought in partners with more data analysis experience than the Medicaid agency had at that time. This relationship also has continued over the years. The Medicaid agency has been active in seeking foundation funding for new program initiatives, and is careful to build an evaluation component into its proposals, thus ensuring additional funding for evaluations if the grant is approved. Finally, the agency has developed extensive relationships with health services

researchers at neighboring Brown University; the researchers participate in ongoing evaluation work groups with the agency and interested stakeholders. They conduct research that focuses on issues relevant to RIte Care, and that also provides opportunities for publication.

## **Virginia**

In contrast to the relatively resource-rich Medicaid agencies in the other case study states, Virginia shows what can be done with a small internal staff, using primarily the type of information routinely produced in most states. As noted earlier, Virginia has lagged behind the other case study states in developing and using encounter data, which has limited the kind of analysis and reporting they are able to do.

The initial 2001 version of Virginia's Medicaid managed care performance report was largely intended to inform the agency's own newly appointed top management, which at the time had relatively little familiarity with the managed care program. Then, in late 2001, the Medicaid agency staff presented a somewhat refined and improved version of that report to its external Medicaid Advisory Committee. Bolstered by the positive response from that committee, the agency staff continued to refine and improve the report, producing a new version in July 2002, another more refined and expanded version in November 2002, and an even more fully developed and updated version in November 2003.

An important transition for many states seems to be the development of a linkage between their summary and ad hoc evaluation efforts and their ongoing program improvement strategies. In this sense, data can be both inputs – identification of problem areas – and outputs – performance information that indicates if problem areas are improving. Another indication of mature program monitoring and assessment is the degree to which other agencies and organizations, such as EQROs, come to rely on state-collected data to explore their own interests and support their activities.

**Lesson 6: Do as much as you can with what you have, and supplement that to the extent possible with outside expertise.**

## **THEME 7: Focusing on Current Concerns and Fixable Problems**

Reports and evaluations have their greatest impact when they focus on issues of major concern to stakeholders, and when they address important problems that need fixing. Reports that states produce regularly in response to statutory, regulatory, or other requirements may warrant reexamination if the concerns that initially prompted them have waned. Similarly, reports that are frequently produced on trends that have stabilized and are unlikely to change might be produced less often or not at all, especially if they divert resources from other efforts that address more current problems.

All of our case study states produce regular standard reports on health plan enrollment trends by plan, geographic area, and eligibility category. These basic data are clearly useful for a variety of purposes, and are not burdensome to collect and report; they have thus become a reporting staple. Data on complaints and grievances and disenrollment may be relevant and illuminating if carefully and consistently reported, but the data can be difficult to collect and report in standardized form. Regular public reporting may not be warranted if complaints and grievances are relatively rare and not increasing, and if disenrollment rates for reasons other than loss of Medicaid eligibility are low and stable.

## **Arizona**

AHCCCS supplements its regular tracking reports (submitted to the legislature and available on the agency's Web site) with ad hoc reports on specific issues of concern to the legislature or governor, such as the impact of eligibility expansion initiatives, options for beneficiary cost sharing, and the cost and utilization implications of carving the pharmacy benefit out of health plan contracts. AHCCCS also prepares an annual statutorily required report on childhood immunizations and has prepared, with foundation support, reports on the impact of the state's managed long-term care system.<sup>31</sup>

## **Maryland**

Maryland's in-depth 2001 evaluation of its Medicaid managed care program focused specifically on whether the program was meeting the goals established at its inception in 1997—an issue very much at the forefront of legislative and stakeholder concerns in 2001. The evaluation also produced valuable baseline measures to be used in the future to examine areas that stood out as potential concerns, including geographic variation in access to providers, services to foster care children, and use of substance abuse services. State officials and plans both noted that another virtue of a well-established protocol for encounter data submission is the ease with which earlier evaluations and analyses can be updated.

## **Rhode Island**

Rhode Island has established an evaluation work group made up of state agency staff, consultants, consumer representatives, and researchers to identify emerging problems and issues that warrant attention. While representatives of the legislature and health plans are not regular members of this work group, the group is attentive to concerns that these stakeholders may have. Evaluations have focused on issues such as the impact of RIte Care on birth outcomes of members, the incidence of lead poisoning among children on Medicaid and the impact of new lead screening and treatment programs, and the impact of beneficiary premiums on enrollment and retention in RIte Care as well as in a new program (RIte Share) aimed at encouraging private insurance coverage.

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<sup>31</sup> Most of the reports are available on the AHCCCS Web site at <http://www.ahcccs.state.az.us/Publications/reports.asp> [Accessed January 7, 2004].

## Virginia

Virginia's managed care performance reports have focused on the benefits of managed care compared to fee-for-service Medicaid, since agency staff believed that these benefits were sometimes obscured by general public skepticism about managed care. The reports also stressed the need to pay health plans rates that will ensure their continued participation, emphasizing the stability of health plan participation in the Virginia program compared to other states that have experienced extensive plan turnover and dropouts. The health plans in Virginia were able to use the reports to help make the case in the 2003 legislative session for health plan rate increases that exceeded those the legislature originally proposed, and those that other health care providers were able to obtain. In addition, as one of the "lessons learned" from its initial performance report, the Medicaid agency undertook a critical assessment of some of its ongoing reports. The agency determined that an annual report required by CMS on complaint data on children with special health care needs was no longer necessary. Not only did the agency receive only a handful of complaints per year, but the associated data collection was very time-consuming and the state had other and better ways of monitoring access and quality of care for these children. CMS agreed to allow the state to drop these specialized complaint reports.

**Lesson 7: Evaluations should focus on current problems and unanswered questions; standard regular reports can cover the basics of ongoing program operations and detail past successes.**

## THEME 8: Internal Value of Evaluation

While the Medicaid agencies in our case study states were generally attentive to the needs and interests of external stakeholders, state agency interviewees all said that some of the most important impacts of their reporting and evaluation efforts were internal:

- AHCCCS interviewees said that better education of the legislature was one impact of their reports, but that the "main impact is more internal." Preparation of the reports pushed the AHCCCS staff to take a closer look at their own performance and that of the health plans.
- Maryland Medicaid agency officials said that meeting their own need to know whether the managed care program was meeting its goals was as important as the external impacts of the evaluation. "We did it so I can sleep at night," one top official said.
- In Rhode Island, the official spearheading the evaluation and reporting efforts said that "the number one audience is us." The "us" included the consumer and other stakeholder representatives involved in the evaluation work group as well as the health plans with which RItE Care contracts.

- In Virginia, the managed care performance report was initially intended to inform top Medicaid agency officials, with no plan to make it available to broader external audiences. The report has now acquired “a life of its own,” a top Virginia managed care official told us. It is “tremendous” for the managed care team, the official said. It “gives them a purpose” and “gives life to the data.” The report “makes everyone stop and think once a year” about where the program is going and its impact.

One important reason for this greater internal impact is that the state officials and staff responsible for running these programs are among the few people for whom caring about the program is a full-time job. (Health plan officials and staff are in the same category.) They also generally tend to care more about broader quality and access issues than most legislators, who tend to focus on Medicaid more as a budget issue and an issue involving individual constituents as beneficiaries or providers. Agency officials also are the persons most likely to be on the “hot seat” in terms of supporting or defending the program and thus want solid evidence to support them in that position.

**Lesson 8: Medicaid agencies are usually more concerned about managed care performance and quality than most outside audiences and have a compelling need to know if their programs are working.**

## **THEME 9: “Awake at the Wheel” – Evaluation as Credibility Enhancement**

Our case study states have found that demonstrating to legislators, CMS, and other stakeholders that the Medicaid agency is sensitive to their concerns and is operating the managed care program in an open, accountable, and cost-effective way enables the agency to be relatively free from day-to-day micromanagement and second-guessing by these external audiences:

- In Arizona, AHCCCS officials told us that “the legislature’s main concern is that we run the program in a businesslike way.” As long as the agency demonstrates regularly and consistently that it is doing so, legislative involvement in managed care operations and even in policy issues remains relatively limited.
- In Maryland, where the legislature, consumer advocacy groups, and the media pay much closer attention to the Medicaid managed care program than in Arizona, Medicaid agency staff nonetheless said that “if we can respond effectively to anecdotes and put them in context, we can avoid formal legislative action.”
- In Rhode Island, as in Arizona, legislative involvement in the Medicaid managed care program is generally limited. In significant measure, Medicaid agency officials attribute that limited involvement to the agency’s ongoing efforts to report regularly and concisely on the RIte Care program’s impact on birth

outcomes, lead screening, immunizations, and other major quality and outcome measures. “The legislature has heard the message about improved outcomes,” program officials say.

- In Virginia, as noted above, the new managed care performance reports helped the Medicaid agency persuade CMS that the agency could dispense with its highly burdensome and generally uninformative reports to CMS on the incidence of complaints regarding care for children with special health care needs. “CMS is happy with what we are doing and has let us stop doing reports that aren’t relevant to Virginia,” a top official told us.

**Lesson 9: The price of freedom is proven performance.**

## **THEME 10: Linking Internal Quality Improvement Efforts and External Reporting**

As Medicaid agencies pursue internal quality improvement efforts, both within the agency and in partnership with health plans, they should be alert for opportunities to highlight their efforts—including both successes and problems—for external audiences:

- In Arizona, AHCCCS officials said that they try to anticipate legislative concerns so they can focus their quality improvement efforts on those concerns and be responsive to key legislators.
- In Maryland, the “holistic” 2001 evaluation of the managed care program helped the agency get beyond anecdotes and make hard recommendations for change.
- In Rhode Island, the legislative staff we interviewed said that the “most remarkable thing” about the officials and staff running the RIte Care program is that they report problems promptly to the legislature and propose fixes.
- In Virginia, legislative staff told us that “we get good data from the Medicaid agency so we can correct problems as they come up.”

**Lesson 10: Focus on fixing things people care about and make sure they know you are working on their problems.**

## CONCLUSION

Measuring managed care performance is not optional. Program evaluation should be seen as work-in-progress that will get better over time, in the same spirit of quality improvement that is found in clinical performance. What aspects of performance to focus on, how to report on it, and to whom can vary with the state context, resources, and program needs. But if states and health plans do not collect and use data on managed care performance, opportunities for improvement will be missed, and accountability and credibility will be undermined. And while good performance may be its own reward, it is usually better if others also know about it.