

EXECUTIVE SUMMARY

The New York Chronic Illness Demonstration Project

**Final Report on an Evaluation of Six Pilot Coordinated
Care Projects for High-Needs Medicaid Recipients**

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Overview

Coordinated care programs are designed to assist individuals with multiple chronic conditions who might require attention from several doctors, risking duplicative tests or prescriptions for contraindicated medications. Such programs try to reduce these risks by helping individuals optimize their use of the health care system and represent an important policy tool for high-needs Medicaid recipients.

In 2007, the New York State legislature approved funding for the Chronic Illness Demonstration Project (CIDP) to provide coordinated care to chronically ill Medicaid recipients. In 2009, six CIDP projects began providing services to individuals with a high likelihood of being hospitalized. The projects used care managers to assess clients' health care and social service needs, educate them on their medical conditions, coordinate care across providers, and help them make and keep medical appointments. Projects also attempted to facilitate individuals' access to appropriate care. The state's goal was to help individuals use more primary and preventive care, in turn reducing emergency room and hospital use and helping to control Medicaid costs.

This report presents results of a study of CIDP conducted by MDRC. The study had two components: an impact analysis of the effects of the projects on health care used through Medicaid, and an implementation analysis of the services provided and challenges faced by the projects.

Key Findings

- **The projects faced a number of challenges implementing the program.** Effective working relationships with other providers and timely information on hospitalization and emergency department visits were difficult to obtain. In addition, inaccurate contact information and residential instability made it difficult to find and enroll individuals in services. Because only 10 percent of eligible individuals enrolled, staff spent time and resources building relationships with a large number of community partners in an effort to locate and serve eligible Medicaid recipients.
- **The program did not appear to reduce Medicaid costs or care from hospitals and emergency departments.** The frequency of primary care visits, hospital admissions, emergency department visits, and use of prescription medications were similar for CIDP-eligible Medicaid recipients and a control group. If anything, the program appeared to increase Medicaid costs slightly, reflecting the costs of providing coordinated care.
- **The projects could have been improved in several ways.** More effective programs have had frequent in-person contact, focused on the transition from hospital to home, and had close interaction between care managers and primary care providers. No CIDP project adopted all these principles. There was variation across projects in most of these areas, although in general they came closer to meeting these standards than did other recent demonstrations.

Although the results suggest the program had little effect on Medicaid costs in its first two years, it is possible that the effects would have emerged after the second year. It is also possible that the program increased the quality of care, the use of social services, or patient satisfaction with care, but the study did not measure these variables.

Preface

Within the Medicaid system, individuals with multiple chronic conditions make up 87 percent of those in the top percentile of Medicaid spending. Many individuals in this high-needs group make extensive use of the emergency room and have repeated hospital stays, which can drive up the cost of care. These problems may be exacerbated by the fee-for-service Medicaid system, which provides little incentive for health care providers to avoid duplicative care, to provide preventive care, or to keep track of the entirety of a patient's health care needs.

One promising idea for helping this high-needs group is the use of health care professionals — care managers — to assess an individual's health care needs and to work with doctors to make sure those needs are being addressed. Many states have some form of coordinated care for Medicaid recipients, but few rigorous studies have been conducted on the effects of such services for a broad group of recipients facing multiple chronic conditions. This report helps to fill the gap by presenting results from the New York Chronic Illness Demonstration Project (CIDP), a set of six pilot programs that was recently operated across New York State. Conceived by the New York State Department of Health (DOH), the six programs provided services to more than 2,300 Medicaid recipients with a high risk of being hospitalized.

The evaluation provided an opportunity to see how the effects of coordinated care would vary across different types of organizations and program structures. Programs were led by a wide range of organizations, from a university-affiliated medical group to a national for-profit health insurer. They also varied across a number of dimensions, including the intensity of services they provided, care manager background, experience in the local community, and access to integrated systems of care for their clients. Because New York has been moving individuals into Medicaid managed care over time, CIDP also presents an opportunity to compare the health care use and Medicaid costs of coordinated care in the fee-for-service system with managed care.

Overall, the results were somewhat disappointing: CIDP resulted in increased Medicaid costs, especially due to hospital inpatient care. Since CIDP shares many of the characteristics of health homes that were established by the Affordable Care Act, the results may provide some lessons for implementing that new model of care, and they could suggest caution in expecting health homes to transform the health care system. But because CIDP providers struggled to recruit, enroll, and serve eligible recipients, and because partway through the demonstration DOH began enrolling some control group members into managed care, these results should also be interpreted with caution.

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Acknowledgments

We would like to acknowledge a number of people who were involved in carrying out this evaluation. MDRC was brought into early discussions about the Chronic Illness Demonstration Project (CIDP) by Melanie Bella when she was at the Center for Health Care Strategies. We received thoughtful comments on evaluation plans and findings from Jay Laudato, Greg Allen, and Pat Roohan at the New York State Department of Health, as well as David Sandman at the New York State Health Foundation. John Billings at New York University helped shape a number of aspects by suggesting a focus on individuals with a high risk of hospitalization, providing information to help MDRC choose a control group for the study, and running the predictive model that determined who was potentially eligible for CIDP. At the Department of Health, the CIDP project managers — Denise Spor (formerly of the Department of Health), Joann Susser, Donna Urban, and Lynn Winne — provided invaluable insights into the day-to-day operations of the projects, while Peter Gallagher and Woo P. Hwang provided similar insights into the state’s Medicaid data. At MDRC, David Butler, Richard Hendra, Helen Lee, and Alice Tufel provided helpful comments on drafts of the report, and Richard Kwong helped collect information on the program’s implementation.

The Authors

Executive Summary

Coordinated care programs are designed to address and circumvent problems that can arise when individuals with multiple chronic conditions seek health care. Such individuals might need to see several specialists, which can result in duplicative tests or prescriptions for contraindicated medications, especially if there is no primary care provider or if that provider is not keeping track of their overall health care use. In addition, complications from untreated or undetected conditions might necessitate emergency care or hospitalization, increasing health care costs. Coordinated care programs attempt to minimize these problems by using care managers to assess individuals' health care and social service needs and help them make appropriate use of the health care system before a medical emergency occurs. These projects may be an important policy tool for Medicaid recipients with complex health care needs, who make up 87 percent of Medicaid recipients in the top percentile of Medicaid spending.¹

In 2007, the New York State legislature approved funding for the Chronic Illness Demonstration Project (CIDP) to provide coordinated care to chronically ill Medicaid recipients. The state hoped these services would help individuals navigate the health care system and use more primary and preventive care in order to reduce emergency department and hospital use and help control Medicaid costs. From 2009 through 2012, six projects provided coordinated care services in various parts of the state.

This report presents results of a study of CIDP conducted by MDRC that had two components: an impact analysis of the effects of the projects on health care used by Medicaid recipients, and an implementation analysis of the services that projects provided and the challenges they faced. The study is part of a four-state Rethinking Care Program developed by the Center for Health Care Strategies to design and test care-management interventions for high-needs Medicaid beneficiaries. In addition to New York, the Rethinking Care Program included pilot tests in Colorado (also evaluated by MDRC), Pennsylvania, and Washington.

¹Richard G. Kronick, Melanie Bella, and Todd P. Gilmer, *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions* (Hamilton, NJ: Center for Health Care Strategies, 2009).

Project Implementation

Overview of the Projects

The Six Projects Varied in Location and Leadership

Table ES.1 provides information about the six projects, summarized below.

1. Healthy Partners of Erie, a project run by State University of New York-Buffalo Family Medicine, an eight-practice medical school group that serves 100,000 patients a year in its primary care clinics
2. Hospital 2 Home, a project run by the New York City Health and Hospitals Corporation, a multibillion-dollar public hospital health care system that serves more than 1.3 million patients annually
3. Live Healthy Care Management, which is operated in New York City by OptumHealth of United Healthcare, a national health plan that insures over 60 million individuals
4. Nassau Wellness Partners in Nassau County (a New York City suburb on Long Island), run by Federated Employment & Guidance Services, Inc., a nonprofit human services system
5. Pathways to Wellness in New York City, run by the Institute for Community Living, Inc., a nonprofit human service provider
6. Westchester Cares Action Project, run by Hudson Health Plan, a regional nonprofit health maintenance organization serving 100,000 members annually in Westchester County (a New York City suburb north of the Bronx)

The New York State Department of Health (DOH) Imposed a Number of Requirements on the Projects

To facilitate referrals and the coordination of services, projects were required to have formal relationships with other providers and to have a method of tracking and sharing data across providers. To establish these relationships, DOH required projects to use a prescribed memorandum of understanding and to have a plan to use electronic health records with registries, decision support, and reminders on evidence-based care. In addition, DOH required that data on benchmarks be reported in a uniform way, although the specific requirements were not finalized until after the projects had begun operations. At enrollment, projects were also

Chronic Illness Demonstration Project (CIDP)

Table ES.1

Description of CIDP Prime Contractors and Partner Organizations

	Healthy Partners of Erie	Hospital 2 Home	Live Healthy Care Management Project	Nassau Wellness Partners	Pathways to Wellness	Westchester Cares Action Project
Prime contractor	UB Family Medicine	NYC Health and Hospitals Corporation	OptumHealth, of UnitedHealthcare	Federated Employment & Guidance Services, Inc.	Institute for Community Living, Inc.	Hudson Health Plan
Type of organization	Medical school faculty practice group	Public hospital health care system	Insurance company	Nonprofit health and human services system	Nonprofit human services organization	Nonprofit health maintenance organization
Catchment area	Erie County	Sections of lower Manhattan, northern Brooklyn, and western Queens	Sections of Queens and the Bronx	Nassau County	Sections of northern Manhattan and western Brooklyn	Westchester County

SOURCE: Information compiled from site-visit interviews and documents from programs.

required to use a specific consent form. Once individuals were enrolled in services, health assessments were to be conducted within 30 days of the client enrolling in care coordination — assessing specific areas, in some cases with specific instruments — and care plans developed within 90 days of enrollment. Finally, projects were required to have in-person meetings with each enrollee at least quarterly and to have at least one type of contact (such as a phone call) each month.

Each Prime Contractor Was Funded to Provide Services for Three Years Starting in 2009

In addition to start-up costs, projects were funded through monthly care-coordination fees ranging from \$205.00 to \$308.33 for each eligible client who met participation criteria. To provide projects with an incentive to reduce Medicaid costs, prime contractors could lose 20 percent of this fee for each client whose Medicaid costs did not decrease as a result of the intervention. To provide an incentive to follow requirements, a project could lose an additional 10 percent of the fee for not meeting certain of them, such as regular contact with clients. Finally, projects could receive part of a savings pool if they reduced aggregate Medicaid costs for enrollees by at least 15 percent.

Project Structure

The Projects Based Their Care-Coordination Models on both Experience and on Theoretical Models

Especially important was Wagner’s Chronic Care model, which emphasizes the interaction of an informed patient with an integrated, team-based health care system. The Wagner model emphasizes the importance of regular, scheduled appointments with care providers that should focus on prevention and that should be followed up with provider-initiated care.² Motivational interviewing — a clinical style used with clients to elicit and activate their own good motives for changing their behavior — was one commonly identified evidence-based practice.³ Many projects outlined a stepped-care approach in which care-coordination services were planned based on severity or degree of disease.⁴

²Edward H. Wagner, “Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness?” (*Effective Clinical Practice* 1, 1: 2-4, 1998).

³Stephen Rollnick, William R. Miller, and Christopher C. Butler, *Motivational Interviewing in Health Care: Helping Patients Change Behavior* (New York: The Guilford Press, 2008).

⁴Michael Von Korff and Bea Tiemens, “Individualized Stepped Care of Chronic Illness” (*Western Journal of Medicine* 172: 133-137, 2000).

Care Coordination Was Provided by Multidisciplinary Care Teams.

These teams were often led by nurses and licensed clinical social workers, although direct contact with individuals was usually provided by staff members with case management, social service, or other health care backgrounds. Care teams also included members who provided support to the care team or their clients, such as housing coordinators, medical consultants, physicians, and peer support specialists (individuals who had progressed in their own recovery from substance abuse or mental health disorders and were trained to assist other individuals with those disorders).⁵

Projects Developed Integrated Networks of Services

Projects developed networks to help locate and enroll individuals and to provide clients with access to a continuum of health, mental health, substance abuse, and social services. The networks included many types of organizations, such as Federally Qualified Health Centers, hospitals, and a wide variety of local nonprofit organizations providing prevention or treatment services. Projects noted several challenges in developing these networks. In particular, the requirement that projects execute a prescribed memorandum of understanding before sharing patient information with partners made it difficult for some projects to turn existing relationships into formal ones for the demonstration. This in turn made it difficult for them to receive timely notification of emergency department visits and hospitalizations and to provide access to needed services.

There Was Substantial Variation in Caseloads Across the Projects

Hospital 2 Home had the lowest caseload, with an average of 23 clients per care manager, while the Live Healthy Care Management Project had the highest caseload, with an average of 89 clients per direct-service staff member.

⁵Center for Substance Abuse Treatment, *What Are Peer Recovery Support Services?* (Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009).

Outreach and Enrollment

CIDP Targeted a Group of Fee-for-Service Medicaid Recipients Who Had a High Probability of Being Hospitalized

Individuals were eligible for CIDP if they were receiving fee-for-service Medicaid and had a high probability of being hospitalized in the coming year, which was determined by a predictive model developed by John Billings at New York University. The three New York City-based projects were each funded to serve 500 individuals at any one time, while the other three projects were each funded to serve 250 individuals.

Projects Struggled to Enroll Enough Individuals

Project catchment areas contained many more eligible individuals than the projects could serve, so only a minority of eligible individuals needed to be enrolled to meet their enrollment targets.⁶ Even so, the projects struggled to meet their eligibility goals, citing missing or inaccurate contact information as a key reason for low enrollment, along with the difficulty of serving a group that included many homeless individuals and others with unstable housing. The DOH-prescribed consent form, which was written at a high reading level, may also have made it more difficult to enroll individuals. In the end, projects enrolled between 8 percent and 20 percent of eligible individuals. Having a small number of clients spread across a wide catchment area and utilizing many health care providers also required programs to spend resources building relationships with a large number of community partners and service providers.

Eligible Individuals Had Substantial Health Care Needs

Because they had a high probability of being hospitalized, it is not surprising that the average person eligible for CIDP had a history of high health care use, incurring nearly \$50,000 in Medicaid resources on average in the year before becoming eligible for CIDP (compared with about \$30,000 for the average New York Medicaid recipient with disabilities).⁷ More than half of the cost was for hospitalization. A substantial portion had been diagnosed with substance abuse (60 percent), mental health problems (50 percent), and cardiovascular disease (40 percent), and a large proportion had multiple chronic conditions.

⁶A “catchment area” is the area from which a program or service draws clients.

⁷Kaiser Family Foundation, “Medicaid Payments per Enrollee, FY2010” (website: <http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee/2010>).

Care Coordination

Care Coordination Included Assessments, Care Planning, Education, and Linking Individuals to Services

The first step in care coordination was an assessment, which helped staff determine their clients' medical, behavioral, and social service needs. Next, staff developed care plans that outlined what would be done to address the identified needs. Staff then began one-on-one work with clients around a variety of issues. For example, care managers used these meetings to make sure clients had a regular source of care and to provide referrals for primary care, social services, peer support, mental health services, and patient education. Finally, the meetings allowed care managers to provide educational information about the chronic conditions an individual faced (sometimes supplementing these one-on-one sessions with group meetings and written educational materials).

Many Individuals Sought Care out of the CIDP Network

As noted above, projects sought to connect clients to medical homes in order to better coordinate their care, but found that many clients already had a regular source of care, often out of the projects' networks of medical homes. Staff also reported that some clients did not like the location of the projects' preferred medical homes. As a result, projects had clients seeking care from a large number of medical homes, but few from providers within the CIDP network, which made it difficult to coordinate care efficiently. Despite these challenges, most projects were actively engaged in the relationship between clients and their primary care providers, for example, by arranging appointments and by giving providers copies of care plans.

Average Face-to-Face Contacts per Month Varied Widely Among Projects

Pathways to Wellness reported close to three in-person contacts per month and Nassau Wellness Partners also averaged more than one in-person contact each month. Live Healthy Care Management reported an average of almost one face-to-face contact per month, which suggests its high caseload did not have an adverse effect on the level of in-person contact. By comparison, Westchester Cares Action Project averaged the DOH minimum of one face-to-face contact per quarter.

Impact Analysis

To estimate the effects of the projects on health care use and costs, two broad approaches were used. Catchment areas for the three New York City projects were divided randomly by zip code into program group and control group areas, and projects were sent information only for eligible individuals who lived in program group zip codes. Catchment areas for the other projects (in the

two New York City suburbs and in the Buffalo area) had too few eligible individuals to allow them to be divided in this way. For those projects, control groups were chosen from other zip codes in the state that had similar demographics and that also had Medicaid recipients with similar histories of health care use. This research design was feasible because resources for care management were limited and DOH was unable to fund services for everyone who might be eligible.

A goal of CIDP was to change the health care environment in program group areas, but the Medicaid environment was also changing in control group areas. In particular, DOH began to require the enrollment of individuals who were not in CIDP into Medicaid managed care, which paid a managed care organization a fixed fee each month regardless of how much care an individual used. As a result, by the end of the first year, 21 percent of the control group was in Medicaid managed care compared with 14 percent of the program group. Differences in outcomes between the program and control groups thus do not represent the effects of CIDP compared with “usual care” but the effects compared with some combination of usual care and managed care. Since one of the goals of managed care is to reduce health care costs by reducing providers’ incentives to provide unnecessary care, it is possible that the program group had higher Medicaid costs and more health care use than the control group because CIDP resulted in smaller decreases in unnecessary care than did managed care.

All outcomes were measured using New York Medicaid data. Following the logic that CIDP should have increased primary care in order to reduce hospital admissions, emergency department use, and costs, a range of outcomes that included costs and measures of health care use were examined, including the number of hospital inpatient days, the number of emergency department visits, and the number of primary care visits. Results from a period of two years were examined because health care use might plausibly rise initially as care managers assessed clients’ health before falling as chronic ailments stabilized.

***CIDP Did Not Appear to Reduce Medicaid Costs, Hospital Admissions, or
Emergency Department Use***

Table ES.2 provides estimates of the effects of CIDP pooled across the six projects. As shown under “Estimated Effect” in the table, CIDP appears to have increased Medicaid costs by about 3 percent (\$1,259) in the first year and 4 percent (\$1,489) in the second year. The increased costs consisted almost entirely of increased costs for hospital inpatient care. One foundation of CIDP was the idea that coordinated care could connect individuals to medical homes that would increase the use of primary care and reduce emergency department visits. Table ES.2 suggests that the project may have been successful in the first regard. In each year, the projects increased the number of visits for primary care by 0.6 per person. However, the

Chronic Illness Demonstration Project (CIDP)

Table ES.2

**Estimated Impacts of CIDP Participation on Health Care Costs
Pooled Across Projects**

Outcome	Program Group	Control Group	Estimated Effect	P-Value
<u>Year 1</u>				
Total costs (\$)	40,933	39,674	1,259	0.014 **
Hospital admissions	16,731	16,068	663	0.054 *
Emergency department	573	529	44	0.002 ***
Average number of events				
Hospital admissions	2.4	2.4	0.1	0.164
Hospital inpatient days	11.7	11.1	0.6	0.002 ***
Emergency department visits	3.0	3.0	0.0	0.798
Primary care visits	13.2	12.6	0.6	0.100 *
Specialist visits	5.2	4.9	0.3	0.098 *
Mental health treatments	7.5	6.6	0.9	0.050 **
Substance use treatments	12.1	12.5	-0.4	0.173
Prescription medications filled	7.0	6.9	0.1	0.250
<u>Year 2</u>				
Total costs (\$)	40,478	38,990	1,489	0.021 **
Hospital admissions	15,156	14,176	980	0.018 **
Emergency department	473	448	25	0.255
Average number of events				
Hospital admissions	2.1	2.2	0.0	0.756
Hospital inpatient days	10.7	10.8	-0.1	0.781
Emergency department visits	2.7	2.8	-0.1	0.228
Primary care visits	10.9	10.3	0.6	0.034 **
Specialist visits	5.0	5.1	-0.2	0.410
Mental health treatments	6.7	5.9	0.8	0.040 **
Substance use treatments	13.5	14.1	-0.6	0.220
Prescription medications filled	6.6	6.5	0.1	0.417
Sample size	16,929	22,092		

SOURCE: MDRC calculations based on Medicaid claims and encounter data from the New York State Department of Health.

NOTE: A two-tailed t-test was applied to differences between the outcomes for the program and control groups. Statistical significance levels are indicated as follows: *** = 1 percent, ** = 5 percent, * = 10 percent.

second half of this formula did not play out: CIDP did not significantly reduce emergency department use in either year, and it significantly increased the number of hospital stays in the first year. There were few significant effects on other measures of health care use, although the projects appeared to increase the number of mental health-related encounters in each year.

There are two reasons to be cautious about these results. First, although randomizing zip codes in New York City should have resulted in program and control group members that were roughly comparable, the same might not hold true for projects outside the city. Since eligible Medicaid recipients in those three projects were compared with similar individuals in zip codes from around the state, it is possible there were some systematic unobserved differences between the two groups that did not show up in prestudy information. If that is true, the results presented above may be biased in one direction or the other. As noted below, however, there was not systematic variation in estimated effects by project.

The higher rate of participation in Medicaid managed care for the control group also provides reason for caution in interpreting the results. In the short term, Medicaid costs for managed care enrollees equal the monthly fees that are paid to managed care organizations for the provision of care. Because DOH and the managed care organizations agreed ahead of time on the size of these payments, they might not reflect the real costs of the resources that individuals in the managed care system used. The higher costs under CIDP may thus be an artifact of the payment system rather than a reflection of true differences in the costs of care. Although the results in Table ES.2 suggest that CIDP also resulted in more health care use, the data on health care use under managed care may be less reliable than similar data from the fee-for-service system. This is because providers in the fee-for-service system are reimbursed based on the care they provide — giving them an incentive to report the care accurately — while information on health care use under managed care is not used for reimbursement. The impacts of CIDP might thus be influenced by differences in data quality between the fee-for-service and managed care systems.

Impacts Did Not Appear to Vary Systematically by Project

As discussed earlier, implementation varied in some important ways across the projects, as did enrollment rates. For example, some projects assigned their care teams smaller caseloads and had more frequent in-person contact with clients. These differences did not translate into differences in program effectiveness, however. In fact, there was little indication that any of the projects achieved the ultimate project goal of reducing Medicaid costs.

CIDP Did Not Reduce Medicaid Costs for Any Subgroup

Although CIDP did not appear to reduce costs overall, it may have been more effective for some subgroups than others. To examine this, the study compared impact estimates for those

with a higher and a lower risk of future hospitalization, those with and without a previous diagnosis for a major psychiatric disorder, and those with and without prior treatment related to drug and alcohol use. These comparisons did not show evidence that CIDP reduced Medicaid costs, hospital admissions, or emergency department use for any of the subgroups.

CIDP Did Not Appear to Be Effective for Those Who Enrolled in the Projects

These early results represent the effects of CIDP for those who were eligible for its services, but because only about 10 percent of the eligible group ever enrolled in a project they severely underestimate the effects for those who did enroll. Two methods (one based on the entire eligible group and one based on only those who actually received services) were used to estimate the effects of CIDP for people who did enroll. Both sets of results suggest that the effects of CIDP on health care use were larger for enrollees than for the eligible group — as would be expected — but neither set of results indicates that the projects reduced health care costs, hospitalization, or emergency department use. In short, CIDP enrollees may have spent more days in the hospital, were more likely to receive primary care, and increased their use of other types of health care, but this increase in services added to costs over the two-year follow-up period rather than reducing costs as intended.

Discussion

The results presented here suggest that CIDP may have increased Medicaid costs over two years rather than reducing them. Those increases came primarily through the increased cost of hospital admissions and the cost of providing coordinated care, although the fact that the control group was more likely to move into Medicaid managed care (which might have reduced their costs) may also explain the higher costs associated with CIDP. These effects did not vary consistently across the projects, and Medicaid costs were not reduced for any subgroup that was examined.

Although CIDP was designed with the best information at hand, results may have been disappointing because the projects did not have many of the characteristics of coordinated care programs found to be effective only after CIDP had begun. For example, several successful programs studied in the Medicare Coordinated Care Demonstration (MCCD) — a random assignment study of 15 coordinated care projects for Medicare recipients — targeted patients at substantial risk of needing hospitalization and used a combination of assessments, care plans, and coaching. All of this was also done in CIDP, but the successful MCCD programs were distinct in that they had frequent in-person contact, access to timely information about hospital and emergency department admissions, and close interaction between care managers and primary care providers; they also relied primarily on nurses within multidisciplinary teams. In CIDP, no project espoused all these principles. There was variation among them in their level of

in-person contact, access to timely information about hospital admissions and emergency department use, contact with primary care, and staffing arrangements.

Projects also faced a variety of challenges that stemmed from the demonstration design. These included inflexibility with memoranda of understanding for partners, uniform data-collection requirements defined after projects started, and incomplete eligibility or contact information. The effects of these challenges on project implementation are evident. For example, care teams typically had significant enrollment and care-management responsibilities that were often difficult to balance. The DOH requirement that projects execute a prescribed memorandum of understanding before sharing patient information with partners made it difficult for some projects to convert existing relationships into formal ones for the demonstration and to develop formal relationships with hospitals, which were expected to provide timely notification of emergency department visits and hospitalizations and access to needed services. Finally, the small number of clients served by any particular health care provider required projects to spend resources building relationships with a larger number of community partners and service providers.

Finally, the research suffered from several major limitations. First, only about 10 percent of eligible individuals enrolled in CIDP services, making it difficult to obtain precise estimates of the effects of the programs, especially for key subgroups of individuals. In addition, the study did not have detailed information on the intensity of the coordinated care services received by those who did enroll in CIDP, making it difficult to know whether the disappointing results are due to lack of engagement in services, or due to a lack of effectiveness of the services that were often used. Finally, the study provided information only on outcomes that were available from Medicaid claims. In particular, the coordinated care programs were intended to increase the use of social services and the quality of care, neither of which was examined by the study. Thus, the generally negative findings on Medicaid use and costs may not tell the full story of the intervention.

In short, CIDP may have been more effective in reducing costs if the projects had been provided with additional resources and support to increase enrollment (allowing for greater efficiencies in areas such as developing relationships with health care providers), if they had designed more intensive services targeted more specifically to clients with conditions that might have responded best to care coordination, and if they had been subject to fewer bureaucratic requirements, which took considerable resources away from other project activities. In addition, limitations of the study's design and length may have led it to miss some key impacts, especially those related to social services and quality of care.

About MDRC

MDRC is a nonprofit, nonpartisan social and education policy research organization dedicated to learning what works to improve the well-being of low-income people. Through its research and the active communication of its findings, MDRC seeks to enhance the effectiveness of social and education policies and programs.

Founded in 1974 and located in New York City and Oakland, California, MDRC is best known for mounting rigorous, large-scale, real-world tests of new and existing policies and programs. Its projects are a mix of demonstrations (field tests of promising new program approaches) and evaluations of ongoing government and community initiatives. MDRC's staff bring an unusual combination of research and organizational experience to their work, providing expertise on the latest in qualitative and quantitative methods and on program design, development, implementation, and management. MDRC seeks to learn not just whether a program is effective but also how and why the program's effects occur. In addition, it tries to place each project's findings in the broader context of related research — in order to build knowledge about what works across the social and education policy fields. MDRC's findings, lessons, and best practices are proactively shared with a broad audience in the policy and practitioner community as well as with the general public and the media.

Over the years, MDRC has brought its unique approach to an ever-growing range of policy areas and target populations. Once known primarily for evaluations of state welfare-to-work programs, today MDRC is also studying public school reforms, employment programs for ex-offenders and people with disabilities, and programs to help low-income students succeed in college. MDRC's projects are organized into five areas:

- Promoting Family Well-Being and Children's Development
- Improving Public Education
- Raising Academic Achievement and Persistence in College
- Supporting Low-Wage Workers and Communities
- Overcoming Barriers to Employment

Working in almost every state, all of the nation's largest cities, and Canada and the United Kingdom, MDRC conducts its projects in partnership with national, state, and local governments, public school systems, community organizations, and numerous private philanthropies.