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Improving Medicaid Policy Through State/University Research Partnerships

Prepared for:

CALIFORNIA HEALTHCARE FOUNDATION

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July 2007

Acknowledgments

The authors thank the leaders from the University of California and the California Department of Health Services (DHS), whose collaboration to explore the feasibility of a Medicaid policy research partnership spawned this project. Dr. Andy Bindman, Gil Ojeda, and others from the UC system and Stan Rosenstein and Rene Mollow from DHS were helpful in identifying the important issues to be addressed and provided numerous insights. The state Medicaid and research center directors and staff interviewed contributed generously their time and provided important observations that are the basis of this paper. And finally, we appreciate the leadership and assistance of Chris Perrone of the California HealthCare Foundation, who was instrumental in the design and execution of the project.

About the Foundation

The **California HealthCare Foundation**, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit www.chcf.org.

ISBN 1-933795-31-X

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Executive Summary

The Medicaid program is one of the country's most significant drivers of health policy, services experimentation, and health care financing. States face constant pressure to justify Medicaid policies, assess the potential impact of proposed program changes, measure program performance, and evaluate reforms designed to maximize the program's cost-effectiveness. Access to information and evidence on what works has become vital to managing an extraordinarily complex program.

Over the past decade, dozens of states have developed formal partnerships with health policy research centers. In 2005, the California HealthCare Foundation funded a team of analysts and former Medicaid directors to examine the feasibility of establishing a joint policy research center at a university in California. The team surveyed six selected state/university health policy research partnerships to learn how they are organized and operate, how well they are working, what issues they have faced in developing and sustaining their collaborations, and how they have addressed those issues. Some of the topics covered were largely descriptive, focusing on the structure, governance, financing, core products/activities, audiences for the work, and staffing of the research center. Potential areas of controversy and conflict were probed, including agenda setting, data access and management, publication policies, and objectivity, independence, and conflicts of interest.

The key findings of this research are summarized here:

- To enhance the sustainability of the partnership, a number of states have developed formal partnership agreements and structures.
- Medicaid directors value the specialized technical expertise provided by the research centers in data analysis, program evaluation, and policy analysis.

- All six of the centers and the state partners engage in a formal agenda-setting process to determine an annual scope of work.
- The experiences of these partnerships highlight the benefits of having staff on both sides of the relationship who can bridge the worlds of policy and research.
- Some partnerships have operated informally with regard to publication rights, but most have developed explicit publication agreements and dissemination procedures to reduce the potential for conflict. Agreements that balance the interests of centers and state partners both (1) allow the center to publish within timeframes that preserve confidentiality for a certain period of time and (2) assure appropriate joint review of findings and documents.
- Research centers and Medicaid agencies are concerned about the real or perceived conflicts of interest created by centers working for other parties, such as the state legislature, provider organizations, or other state agencies. Ground rules for communication about such engagements are an important tool to prevent and manage potential conflicts.

State-level university-Medicaid research partnerships represent an important and growing innovation in the health services research field that have gone largely unrecognized for the value they bring to policy development. Likewise, the challenges and the means for overcoming them are not widely known. The partnerships studied in this project are highly valued by both the universities and the state Medicaid agencies. In particular, such partnerships allow a state to establish a long-term relationship with a non-profit, public entity that knows them and their business well. This familiarity, combined with the relationships that develop over time between university center staff and Medicaid officials, enhances the relevance of the research to the needs of the Medicaid program. The experience of these states indicates that institutional and organizational

leadership and organizational culture in the university and the state Medicaid agency are critical determinants of the success and sustainability of these partnerships. Universities and Medicaid agencies recognize the risks in these partnerships and all of the longer-term partnerships we studied have managed the risks and sustained the partnership through broad-based agreements and the involvement and support throughout the Medicaid agency and the university. In addition, success and sustainability are more likely with multi-year financing commitments that support infrastructure development and process activities as well as funding for targeted projects.

Introduction

As Medicaid has evolved from a welfare-based health program for low-income people to the largest public insurance program in the country, the importance of understanding the complex dynamics of the program and the people it serves has never been greater. Despite methodological and other challenges with Medicaid research (such as the difficulty of extrapolating results of Medicaid studies to other states), the program is recognized as one of the country's most significant drivers of health policy, services experimentation, innovation, and health care financing.

For states, which make almost all Medicaid policy decisions, access to research and analysis, policy and program evaluation, and other research-based assistance has become vital to managing this extraordinarily complex program. External forces such as federal requirements for independent evaluations of experimental Medicaid initiatives and increasing stakeholder scrutiny have spurred interest in Medicaid research. Independent assessment of sometimes controversial initiatives including managed care, restricted pharmaceutical formularies, consumer-directed care, and increased beneficiary cost-sharing can contribute objective analysis to debates that otherwise may be steered by ideology and anecdotes.

As interest in and demand for Medicaid-related research has increased, so has the number of university-based state health policy research centers specializing in Medicaid. In a 1998 study co-author Coburn examined the role of university-based health services research programs in state health policy.¹ At the time, only a handful of centers with faculty, staff, and research programs were committed to studying Medicaid and other state health policy issues. Today, there are dozens of such centers, many of them created in the past five years. Partly in response to this growth, AcademyHealth, the professional association representing health services researchers, initiated a State Health Research and Policy Interest Group that has become its second-largest and fastest-growing interest group. What is driving this growth in state/university research partnerships? How are they organized and financed? What roles do they play and how do they influence Medicaid and state health policy and programs? What are the most critical factors determining the effectiveness of these collaborations?

In 2005, the California HealthCare Foundation funded a team of researchers—including former Medicaid directors—to examine these questions as part of a feasibility analysis for establishing a collaborative, Medicaid/university policy research center in California. Selected state Medicaid/university health policy research partnerships were examined to determine how well they work, what challenges they face in developing and sustaining their collaborations, and how they have addressed those issues.

Program officials, policymakers, and researchers want relevant, research-based information to aid in policy development. A formal partnership creates a structural link between university-based research and state policy and practice, increasing the likelihood that each will influence the other. Forging that link, however, challenges the cultures of both Medicaid program leaders and

researchers. Medicaid officials and the political leaders to whom they report must contend with concerns about information control and the tendency to regard any external party as a potential political adversary. Researchers must overcome concerns that a close association with policymakers could erode their objectivity and academic freedom.

Approach

This survey focused on states and university research centers with well-established partnerships. The authors began with a list of 15 states where university-based health services research or policy programs are engaged in Medicaid-related work, and selected six that have formal partner-

Table 1: State/University Medicaid Research Partnerships

State	Center	Description
GA	Georgia Health Policy Center	Located in the Andrew Young School of Policy Studies at Georgia State University in Atlanta, the center conducts state and national research, policy development, and program design and evaluation projects, though much of its work has been focused on state health policy and programs in Georgia.
ME	Institute for Health Policy	A part of the Muskie School of Public Service, the institute has been a partner for more than 20 years with the Maine Medicaid program on applied research and evaluation, policy analysis and development, data management and analysis, and technical assistance projects addressing such topics as Medicaid financing and reimbursement, long term care systems, quality management, and SCHIP.
MD	Center for Health Program Development and Management	The center is located at the University of Maryland, Baltimore County. Since 1994 the center has collaborated with the Maryland Medicaid program on research, evaluation and technical assistance projects related to Medicaid rate-setting, managed care, data warehousing and analysis, and long term care.
MA	Center for Health Policy and Research	The center was established in 1997 at the University of Massachusetts Medical School to promote collaborative evaluation and policy development efforts with state agencies, including Medicaid. The center is part of Commonwealth Medicine, through which UMass Medical School provides research, evaluation, and analytic services; offers clinical and/or other services and support; and oversees programs for state agencies such as the state public health lab.
MI	Institute for Health Care Studies	The institute conducts research, evaluation, and other projects focused primarily on Michigan. It was established with funding from the state Medicaid program to provide evaluation, analytic, and other support to the state's Medicaid managed care initiatives and has continued to have a portfolio of Medicaid-related projects.
NJ	Rutgers Center for State Health Policy	Located in the Institute for Health, Health Care Policy, and Aging Research, the center conducts health policy analysis, research, training, facilitation, and consultation on state health policy. The center has worked extensively with Medicaid and other agencies in New Jersey and other states on projects related to long term care, access to health care, racial and ethnic health disparities, health care performance measurement, pharmaceutical policy, and state health data and information.

ships. Three members of the project team represent two university-based centers with longstanding Medicaid and state health policy research and policy programs; these centers were included in the survey, since this project is not intended as formal research. Table 1 provides a brief description of the six centers surveyed.²

The team used a semi-structured protocol to interview the Medicaid directors and university center directors in each of the six states. Some of the topics were largely descriptive, focusing on structure, governance, financing, core products/activities, audiences for the work, and research center staffing. Other questions probed areas of potential controversy and conflict, including agenda setting, data access and management, publication policies, objectivity, independence, and conflicts of interest. All interview subjects were also queried regarding the unique attributes of their partnerships and the key lessons learned.

Models for State/University Research Partnerships

The ingredients for successful policy research collaboration and research utilization have been widely discussed in the literature.³⁻¹⁰ This survey focused on six key questions:

1. How are these partnerships structured and governed?
2. What staffing capacity is needed to develop and sustain effective partnerships?
3. How are priorities determined and how do the partners decide which issues and programs will be examined?
4. What are the core products of the partnership and who are the audiences for the work?
5. Is maintaining the objectivity and independence of the partnerships' research a problem? How are potential conflicts of interest handled?

6. What issues do the university and the state face concerning confidentiality, dissemination, and academic freedom and how are they handled?

Structure and Governance of Partnerships

The six partnerships surveyed have developed increasingly formal structures and governance agreements to manage the complex scope of work and corresponding relationships. The three oldest partnerships have overarching master agreements that govern the partnerships' activities and administration. The other three are more loosely structured around annual agreements that address the proposed scope of work and administrative issues, similar to contracting instruments.

The master agreements articulate the purpose of the partnerships and address generic issues such as publication processes, ownership of products, and data access. In each case, master agreements were executed by officials higher than center directors and Medicaid directors such as a chancellor and secretary, providing high-level political support for the partnerships.

An important benefit of these master agreements has been to promote long-term relationships. An implicit or explicit multiyear commitment has supported capacity building at the university centers and enabled them to dedicate faculty and staff time to partnership work. Some centers report that multiyear funding has enabled them to hire and retain a specialized faculty or staff member who brings particular knowledge and skills to the partnership, rather than relying on existing faculty and staff for whom the partnership may be a secondary priority. Multiyear commitments also have been helpful in leveraging university investments in faculty and staff and other infrastructure development to support these partnerships.

The university centers have adopted a variety of organizational forms to structure their Medicaid-related work. In three of the centers, the Medicaid partnership has been a primary focus of the center's work, with a nearly 100 percent dedicated staff. These centers have built substantial Medicaid expertise and have the capacity to be very responsive to state Medicaid needs but may risk being regarded as extensions of the Medicaid agencies, rather than as independent university research centers.

Matching University Staff Capacity with Medicaid Program Needs

Medicaid directors pointed to the technical expertise provided by centers in data analysis generally, and in specific areas such as evaluation, rate-setting, and policy analysis, as a major benefit of partnerships. Medicaid agencies have difficulty recruiting highly trained researchers and analysts because they can't offer competitive salaries or the teaching and consulting opportunities available at universities and research firms. But state leaders also note that not all academics have the skills or interest in the applied research, policy analysis, and technical assistance that states need. The experiences of the six centers surveyed suggest that this is an important issue fundamental to the success of any state/university health policy research partnership. The work that states have pursued through these partnerships requires a core set of skills and knowledge, including a sound understanding of the Medicaid program and policy, an understanding of and appreciation for the policy and political context of the issues being addressed, an ability to design and carry out studies quickly, and an ability to distill findings and communicate them in a format that meets the needs of policymakers. Also important is a commitment to collaborative approaches that engage policymakers and others in formulating research questions and interpreting results.

Researchers must understand the Medicaid program and policy in order to ask questions relevant to the decisions Medicaid leaders must make. Likewise, the history and context of an issue is often central to understanding what information could be most useful for decision-makers.

Not every health services researcher has an interest in or patience for the intricacies of Medicaid policy and context. For this reason, centers have sought out faculty and staff to ensure good matches with their Medicaid work. Centers vary in staff composition, but most have a mix of faculty, policy/research staff, and programmers/data analysts. While it is important to have enough senior faculty involved in the center to provide intellectual leadership, a core staff with significant Medicaid interest and experience is even more critical. This is especially true in centers charged with doing short-term, quick turn-around projects and reports.

Brokers and translators have been crucial to the success of state/university partnerships. In an ideal partnership, staff in the Medicaid agency understand how universities and researchers operate and university staff know the Medicaid program well. Co-location of key staff is one strategy for fostering the translator role. The accessibility of center staff to the Medicaid agency helps to build relationships and Medicaid knowledge, spot opportunities for relevant analysis and research, and obtain valuable, informal input as projects develop.

Medicaid directors note that agencies must devote time and energy to working effectively with a center. Collaborating on a research agenda that aligns with program needs, providing access to data, and reviewing products require commitments at various levels of a Medicaid agency, from data managers to the director. Politically sensitive studies require Medicaid directors to brief and gain support from their superiors, including commissioners, secretaries, and governors.

Medicaid Data and Data Capacity

Analysis of Medicaid data (including eligibility, claims, and assessment data) is clearly an area where both the Medicaid agency and university researchers can benefit from partnering. To take advantage of mutual opportunities, centers must have a strong programming and data analytic staff experienced with Medicaid data. Researchers who are new to the idiosyncrasies of Medicaid data initially need help using and interpreting the data as well as understanding policy evolution and coding changes that produce data anomalies.

Centers use two basic models of data access. Three of the six centers surveyed maintain or have direct access to comprehensive Medicaid data files and need only to request permission to use it for specific research projects. The other three centers receive data files for each project.

Direct access to Medicaid data seems more efficient and reduces delays for data acquisition. This is especially important when centers are involved in quick turnaround projects.

Most centers use personal health information in their analyses. Compliance with federal HIPAA privacy protections is achieved with a business associate agreement between the center and Medicaid agency.

Reconciling Academic and Policy Needs: Setting Research Agendas

Deciding which issues and programs to examine would seem to present significant potential for conflict. Medicaid directors need policy-relevant research addressing immediate program challenges, while university researchers may want to pursue personal interests. But there was relatively little tension surrounding this issue in the six states surveyed. This is undoubtedly due in part to the fact that these are well-established partnerships that have found ways to balance the interests of the Medicaid agencies with those of the university centers.

All six centers and their state partners engage in an agenda-setting process to decide the annual scope of work. Typically, the parties meet to propose projects, which then get prioritized to fit a budget. Both parties agree to the annual scope of work in a contract. Centers note that the Medicaid agency, as a primary funder of the work, has greater influence in selecting projects. Centers have more influence when they arrange for third-party funding (from a foundation or federal agency, for example). Most centers are actively engaged in developing proposals to external funders in which the state is the applicant or major partner.

How much effort should be devoted to research and how much to policy development is an issue often at the heart of agenda-setting discussions. Medicaid agencies typically value information that centers produce from their data. But seldom are they able to wait for the results of formal, multiyear studies, since most Medicaid policy decisions must be made quickly through a public, political process. It might be ideal for these partnerships to project where the issues might be in three to five years. Unfortunately, such forecasting depends in significant part on program leadership; stability in program leadership over a period of this length is increasingly rare, with the average tenure of a Medicaid director now often measured in months rather than years. Moreover, it is difficult to predict the changing direction of Medicaid policy from year to year.

External stakeholders indirectly influence agenda setting, often through the legislature or the governor's office, and sometimes directly to the Medicaid agency. For example, a state legislature may direct a Medicaid agency to conduct a study or to develop and implement a new reimbursement methodology. When this occurs the agency often proposes adding the work to the center's agreement for the year.

The agenda-setting process also guides the centers' internal long-term development plans. Over time, centers identify staff or other capacity needs to serve the partnership in topical areas (such as behavioral health) or methodological areas (such as forecasting) that are important to address.

Core Products and Audiences

Medicaid agencies are usually the primary audience for the centers, which produce a wide range of “user-driven” products including formal research, policy reports, briefing papers, informal quick analyses, memos, and other decision-oriented materials. Most centers consider the legislature, other executive agencies, and other states as important secondary audiences for their Medicaid-related work.

A degree of tension typically exists between the state agency's need for useful and timely memos, informal reports, and other products targeted to practical policy or operational issues and the desire for more formal reports that have the added value of being perceived as independent and objective. Peer-reviewed publications tend to

be secondary products and are infrequent. The issue of publication and dissemination rights, discussed below, has been contentious in several states and requires explicit agreements to avoid serious conflict. In general, however, limited time and funding have been more significant barriers to publication and dissemination of center products than Medicaid agency resistance. Table 2 details center products Medicaid directors have found useful.

Centers increasingly use technology to facilitate open access among partners to data, analyses, documents, and reports. Technologies such as intranets allow easy sharing and retrieval of relevant documents and other materials on a real-time basis, which promotes closer collaboration among university and Medicaid agency staff.

Objectivity, Independence, and Conflict of Interest

It is important to both universities and Medicaid agencies that center research be objective and independent of Medicaid agency influence, and both sides understand that a close working

Table 2: Examples from Medicaid Directors of Useful Center Products

Program Evaluation	<ul style="list-style-type: none"> • Evaluation of a multidisciplinary prenatal care program for high-risk women that led to a restructuring of the program.
Policy Analysis	<ul style="list-style-type: none"> • Analysis of a proposed provider tax. • Assessment of the impact of eliminating chiropractic services on cost and access.
System Analysis	<ul style="list-style-type: none"> • Analysis of the state's long term care system, with issues, options, and recommendations including best practices from other states.
Reimbursement Methods	<ul style="list-style-type: none"> • Analysis of the reimbursement methodology for Disproportionate Share Hospitals. • Development of an acuity-based, risk-adjusted reimbursement system for long term care. • Development of a performance-based incentive payment system for physicians.
Impartial Technical Assistance to Stakeholders	<ul style="list-style-type: none"> • Staff for a long term care task force. • Staff for a provider tax task force.

relationship can create at least an appearance of bias. Medicaid directors reported that centers were accepted generally as objective sources of analysis by most stakeholders. One director suggested that a center that works exclusively for a Medicaid agency could lose its reputation for independence and risk being seen as merely an extension of the Medicaid agency.

Centers reported no serious public challenges to their objectivity and independence. They take specific steps to help dispel any perceptions of capture by the Medicaid agencies, including maintaining diversified portfolios of research with funding from multiple sources.

Research centers and Medicaid agencies also strive to avoid real or perceived conflicts of interest. Conducting studies directly for the legislature, for example, could be problematic because of the constitutional separation of powers. Even centers that receive direct appropriations typically have little direct interaction with the legislature or individual legislators, and do little work for them. Centers disclose any such activities to their executive agency partners.

Centers also are sensitive to party politics. In states where the legislative and executive branches are controlled by different parties, centers do not want to be perceived as having a party bias. In some cases, centers have served a delicate role as the go-between for the Medicaid agency and the legislature.

Centers at universities that also provide health services, such as academic health centers, face additional potential conflicts. For example, a university could help a Medicaid agency assess the impact of changes in Disproportionate Share Hospital payment policy, which might affect the university's medical center. Only one of the centers surveyed has an indirect relationship with an academic health center, and neither the university nor the Medicaid agency perceived the issue as significant. Nevertheless, partnerships should

develop explicit rules of engagement (such as ensuring firewalls on key issues) where such potential conflicts exist.

Centers identify work for other executive branch agencies that rely on Medicaid for program funding as another area of potential conflict because Medicaid generally views these agencies as stakeholders seeking to maximize their Medicaid funding. Centers disclose these situations to the Medicaid agency when they arise. In some states, the university has played the useful role of brokering discussions and joint studies between Medicaid and another executive agency.

Confidentiality, Dissemination, and Academic Freedom

Universities have traditionally maintained a standard of academic freedom that strongly supports open exchange of ideas and information and preserves the right of faculty to communicate and publish the results of their work. State Medicaid agencies, however, operate in a highly charged political environment. They often need to maintain confidentiality of work done in support of Medicaid policy development and operations, and they desire to control the timing and method of release of research or analysis. Therefore, publishing can become a contentious issue in most partnerships.

Some partnerships have operated informally with regard to this issue without any reported problems, but most rely on explicit agreements on publication rights and dissemination procedures. Agreements that balance the interest of centers and state partners tend to both (1) allow centers to publish within timeframes that preserve confidentiality for a period of time, and (2) assure appropriate joint review of publications.

Conclusion

Each of the state/university research partnerships in the survey has different structures, capacities, and research and policy focus. These differences are the product of their state context, the founders' vision, the capacity and needs of the Medicaid agency and the university, and available resources. Despite these differences, these six partnerships shared a number of experiences that provide lessons on achieving success.

First, these partnerships are highly valued. Most Medicaid programs contract with many vendors providing research, analytic, or evaluation services. What sets the university partnerships apart? Perhaps most importantly, the partnerships allow states to establish long-term relationships with nonprofit, public entities that know them and their business well. This familiarity, combined with the relationships that develop among center staff and Medicaid officials, reportedly contributes to more relevant research for the Medicaid program. It makes it easier to swiftly develop and carry out projects. The Medicaid agency often can quickly fund work without being slowed by the usual competitive request-for-proposals process.

These partnerships also are different in that they allow states to leverage funding to universities from non-state sources (such as foundation grants and federal grants) to conduct Medicaid research that is relevant and timely to their business decisions. In addition, most centers contribute state dollars to support the work of the partnerships.

To achieve these benefits, however, the Medicaid director and management team must value research as an important component of program planning and improvement and must be able to trust an external party with politically sensitive information. Likewise, universities report significant benefits, especially in longer-term partnerships that afford the opportunity to build a critical mass of interested, committed, and productive faculty and staff.

A second lesson is that institutional and organizational leadership and organizational culture in the university and the state Medicaid agency are critical determinants of the success and sustainability of these partnerships. In the university, presidents, deans, faculty, and other leaders must value the public service nature of the applied work. Many larger research universities typically place much greater value on federally funded research, which has more potential for national recognition and usually provides greater financial support through indirect cost recovery.

In Medicaid agencies, continuity of leadership, a perennial challenge, is an important but not controlling ingredient for success. All of the longer-term partnerships studied have been sustained through broad-based agreements and support throughout the Medicaid agency and the university. Success and sustainability is more likely with multiyear financing commitments that support infrastructure development and process activities, and not just short-term projects.

Third, universities and Medicaid agencies both bear risks in these partnerships. For Medicaid agencies, the primary risk is the potential for untimely disclosure of sensitive information, due to third-party involvement in the agency's confidential work. The primary risk for universities is the real or perceived loss of independence because of close engagement with state partners.

There is a danger that government downsizing could reduce state/university research partnerships to meeting routine operational data management, analysis, and other agency needs typically handled by Medicaid staff. Partnerships face the challenge of maintaining focus on longer-range topics in which the university's research expertise is put to its best use.

Fourth, the experience of these partnerships reinforces what many others have said: Successful research-to-policy partnerships benefit by having

staff on both sides of the relationship who can broker or interpret.^{11, 12} These roles help researchers and analysts understand the policy problems they are asked to address and interpret results in a manner that enhances the usability and impact of the information.

And finally, the success of these partnerships requires attention to the issues of objectivity, confidentiality, and academic freedom. Objectivity, both real and perceived, is possible by maintaining a mixed portfolio of research and building firewalls between the research center and other parts of the university. With deliberate attention and carefully constructed agreements, partnerships have been able to balance the states' need for confidentiality with the centers' commitment to disseminating the results of their work.

State/university research partnerships represent an important and growing innovation in the health services research field that has gone largely unrecognized for the value it brings to policy development. Likewise, the challenges and the means for overcoming them are not widely known. If the Medicaid program continues to grow and evolve at its current pace, there will be even greater demand for research-based information on the program's efficiency and effectiveness. The relevance of the work of existing state-based partnerships is limited by the problem of generalizing results. Given that no two state Medicaid programs are alike, one of the important challenges for the field is to develop formal state-to-state Medicaid research and policy collaborations that will enhance the value of the research carried out by each partnership.

Endnotes

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