

Case Studies in Medicaid Managed Care

**A MANAGEMENT SUCCESS STORY:
THE PENNSYLVANIA MEDICAID
MANAGED CARE PROGRAM**



Jocelyn M. Johnston



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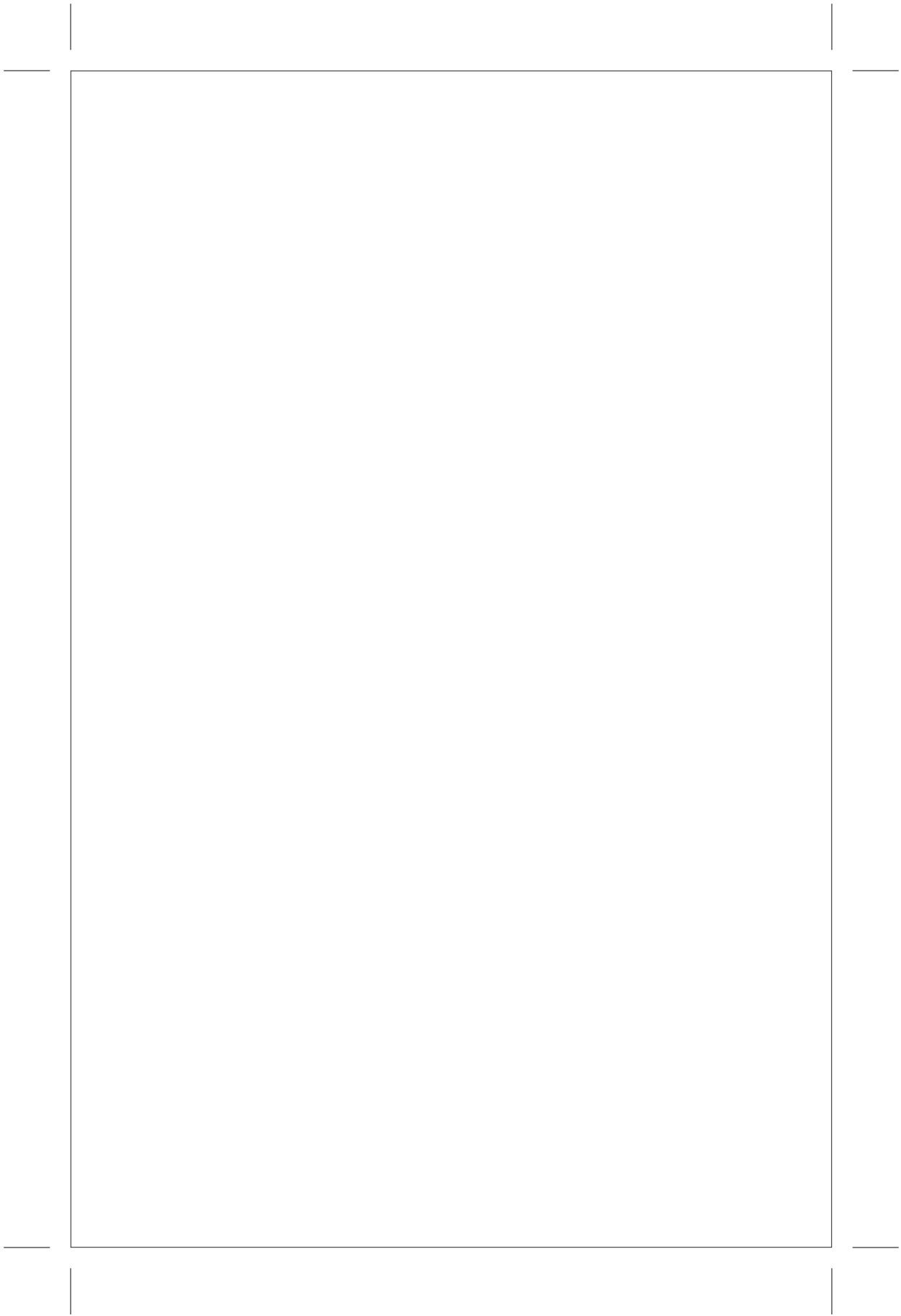
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Introduction

In the past decade, states have moved aggressively to use managed care — especially capitated, or full-risk models of managed care — to deliver Medicaid services to their low-income populations. Yet the capacity of states to manage this health care reform varies considerably. Very few states have met the management standards embodied in the notion of “prudent purchasing” (Fossett et al., 2000). Prudent purchasers design contracts — typically with HMOs or other managed care organizations — that specify measurable performance standards for quality and other aspects of health care, collect data to measure performance, and use that data to evaluate, reward, and/or sanction health care provider performance.

The evidence gathered for this report indicates that the Commonwealth of Pennsylvania has created the organizational and management capacity necessary to meet the standards of prudent purchasing with its *HealthChoices* Medicaid managed care program. Recent studies of state government performance indicate that management capacity makes a real difference in the quality of policy formulation and implementation (Coggburn and Schneider, 2003; Donahue, Selden, and Ingraham, 2000; Heinrich and Lynn, 2000; O’Toole and Meier, 1999). This seems to state the obvious, but the research offers compelling evidence that investments in management infrastructure pay off. Because Medicaid provides such critical services and comprises a substantial portion of most state budgets, the management of Medicaid programs — and Medicaid reforms such as managed care — is especially important.

The success of Pennsylvania’s Medicaid management is attributable to a variety of factors:

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- ❖ Early recognition by the state’s Medicaid administrators, supported by political leaders, that “you can’t do this on the cheap.” Medicaid managed care, in the view of these policymakers, will not save money, but it will at best reduce cost growth. Resources for program management are essential.
- ❖ Strong political support — support that frees managers to focus on programs and policy as opposed to putting out political “fires.”
- ❖ A managed care marketplace that favors the state as a purchaser.
- ❖ Outstanding management leadership and stability, reinforced by an emphasis on recruitment and staff development.
- ❖ Concentration on contract management techniques, using interdisciplinary teams dedicated to building strong partnerships with providers.
- ❖ Upfront investments in program design, building on lessons learned from managed care pilot programs. Tough issues were tackled early, thereby maximizing service improvements and cost effectiveness, especially for Medicaid recipients with special health care needs.
- ❖ A decision to rely on Medicaid-only HMOs, which has enhanced the state’s purchasing power in the managed care marketplace and the quality of services to enrollees.
- ❖ The respect of the Medicaid HMO contractors, which are held strictly accountable, but whose administrators trust the state to understand their needs and to help them improve their performance.

- ❖ The scrutiny of an exceptionally strong health care advocacy organization that pushes the state and the HMO contractors to refine the program and improve services to Medicaid patients.

The state's top Medicaid administrators believe that Pennsylvania has one of the best Medicaid management organizations, close on the heels of Arizona and Massachusetts. This assessment is shared by the administrators of the HMOs that contract with the state, and is consistent with Pennsylvania's above-average grade in *Governing's* Government Performance Project (Barrett et al., 2001).

This report, which is based on data collected in the fall of 2002, provides substantial support for these assessments of Pennsylvania's Medicaid management organization.¹ Although Pennsylvania suffers from some of the same problems that plague other state Medicaid management systems (Fossett et al., 2000), it enjoys an enviable political and market environment. This environment has freed Medicaid managers from some of the political and economic problems that divert management time and attention in other states. The Pennsylvania management environment therefore allows an exceptionally effective management team to focus its energy on program design, purchasing strategies, and performance oversight.

A great deal of Pennsylvania's Medicaid management success is attributed to its management design — especially the use of a matrix management model that relies on "Core Teams" to monitor contractor performance. Like many other states, Pennsylvania emphasizes the oversight of health service quality, but it is distinguished by its effective management of performance in other areas of Medicaid managed care, including financial performance, an area that is inadequately monitored in several states. Evaluation and analysis are relatively sophisticated, and the state is in a position to use program information to reward and sanction performance as needed. In addition, Medicaid administrators are kept on their toes by an unusually strong health advocacy group that closely watches policy and programmatic performance and that prompts the state to continually fine-tune its operations.

Pennsylvania had one of the earliest Medicaid managed care pilot programs — an ancestor of the current program — and a child health insurance program that predated the federal CHIP. It has a record of innovative health policy. This report suggests that it has also demonstrated significant success in managing its most recent significant Medicaid reform.

A Brief History of Medicaid Managed Care in Pennsylvania

Although Pennsylvania has adopted mandatory managed care only in the last few years, the commonwealth served as the site for one of the very first Medicaid managed care pilot programs for welfare recipients. Known as *HealthPass*, this pilot operated in Philadelphia through a federal Medicaid waiver. *HealthPass* was plagued by a variety of problems; consequently, state administrators learned valuable lessons that were incorporated into the design of the current program (Hurley, 1998). *HealthChoices*, the state's mandatory full-risk Medicaid managed care program, retains the core concepts of *HealthPass*, and has now been implemented in three regions.

The movement toward mandatory Medicaid managed care originated in the Casey administration, but the current program model was refined and implemented in the years since Republican Governor Tom Ridge succeeded Casey in 1994. During the Ridge years, the legislature in Pennsylvania has also been predominantly Republican.² As in other states, Medicaid cost containment has been an important objective in Pennsylvania, which historically has had relatively high levels of Medicaid spending, both per capita and as a share of the overall budget (Birnbaum, 1998).

HealthChoices is operated by the Office of Medical Assistance Programs (OMAP) in the Department of Public Welfare (DPW).³ The unit charged with the lion's share of managed care management is OMAP's Bureau of Managed Care Operations (BMCO). *HealthChoices Southeast*, which covers counties in the Philadelphia

metro area, was launched in early 1997. Despite a bumpy first year which was marred by serious financial problems for some HMOs (Birnbaum, 1998), *HealthChoices Southwest*— which includes Pittsburgh and surrounding counties — followed two years later. By late 2001, when *HealthChoices Lehigh/Capital* began operating in Harrisburg and the state’s south central counties, roughly 750,000 managed care enrollees were being served statewide. These three geographic areas now enroll approximately 55 percent of the state’s eligible Medicaid population. The next phase of implementation will extend mandatory coverage to the more rural northeastern counties. By 2005, the state plans to have statewide mandatory managed care.

As of the fall of 2002, Medicaid officials recognized that the next phases of implementation could be difficult. The state’s purchasing power, relatively strong in the existing *HealthChoices* regions, will face challenges in the rural areas where resistance to managed care is relatively strong. The Medicaid management team has been very stable since the program was refined and re-launched in the early years of Governor Ridge’s administration, but there are concerns about whether “leadership bench strength” is adequate to move the program into its next phase. In addition, the transition to a new administration with the election of former Philadelphia mayor Ed Rendell could bring changes in the political and market environment. Yet despite these concerns, the state has a clear record of management success in the last decade.

Pennsylvania’s Medicaid Management Environment

The management environment for Pennsylvania’s Medicaid managed care program is characterized by a program design, a political environment, and a managed care market structure that allow — indeed, push — Medicaid administrators to invest their resources in program management. In many other states, these factors work against management and divert energy, often at the expense of policy and program quality (Fossett et al., 2000; Johnston, 2002).

Pennsylvania’s Medicaid managers do not need to dedicate scarce resources to putting out “fires” — fires created by political and market factors that complicate managed care programs, or by inherent flaws in their program designs.⁴ They are instead free to focus their time and expertise on monitoring and improving service delivery.

Program Features

A crucial early management decision, based in part on experience with *HealthPass*, was to explicitly recognize that the state’s commercial HMOs were not well-prepared to manage care for Medicaid recipients. This recognition led to the exclusive use of Medicaid-only HMOs — i.e., entities created to deal exclusively with Medicaid managed care patients. In addition to the benefits of specialization, this approach enhanced the state’s purchasing power. Medicaid-only HMOs are far more dependent on the state’s business — and thus more willing to accept state performance expectations — than commercial HMOs would be.

Medicaid officials believe that some of their success is due to the fact that they tackled the most difficult design issues early on. Behavioral health is the only carve-out, and all other special needs are served through the physical health HMOs.⁵ One of the major requirements of the *HealthChoices* contracts is the establishment of special needs case management through a Special Needs Unit (SNU) within each plan.

The emphasis on special needs populations, including those with disabilities, maximized improvements in service quality and cost savings. The SNUs serve a variety of special needs, but asthma, prenatal care, high blood pressure, and diabetes — i.e., manageable but chronic conditions that can generate high acute care costs — are some of the most common special needs. The SNUs augment HMO care by identifying external resources to provide customized services to enrollees. Although the SNUs have generated unexpectedly high demands on the HMOs, with a ten-fold increase in SNU case managers over the life of the program,

the benefits are substantial. Medicaid officials believe that the enhanced quality of services tailored to enrollees, together with the resulting savings from reductions in acute health care costs, justify the administrative demands.

BMCO designed the program so that each HMO can potentially capture a market share of roughly 35,000 enrollees. This was originally calculated by BMCO, with help from the William Mercer consulting firm, as the break-even membership base number for the HMOs. The geographic phase-in areas were configured with this figure in mind to ensure that HMOs in each area are able to reach adequate enrollment levels. This contrasts with designs in other states, such as Ohio, where contracts have been county specific. Several HMOs dropped out of the Ohio Medicaid market in the late 1990s, and the low enrollment bases associated with the program design contributed to the problem.

In addition to *HealthChoices*, the state also operates a primary care case management (PCCM) program, known as *Family Care Network*, which is mandatory for all child Medicaid enrollees in those counties not covered by *HealthChoices*. All adults in non-*HealthChoices* counties are served through fee-for-service (FFS) Medicaid, but *HealthChoices* is available on a voluntary basis in several of the counties still not included in the mandatory program. The state's staff therefore administers four types of welfare-related Medicaid programs — both mandatory and voluntary capitated managed care, PCCM, and FFS. As a result, OMAP has retained flexibility while finetuning its mandatory program, and has used a variety of approaches that fit the state's varied demographic and market conditions. In some other states, by comparison, managed care was extended statewide before the program was really seasoned, and when failures occurred, there was no fallback health care infrastructure for Medicaid recipients.

Like most other states, Pennsylvania focused its initial mandatory programs on urban areas. Now that *HealthChoices* covers Philadelphia, Pittsburgh, and Harrisburg and the counties surrounding these cities, the state is poised to tackle the more difficult task of bringing managed care to rural areas. Administrators

intend to follow the same basic *HealthChoices* model in these areas and they now have a group of potentially interested Medicaid HMOs, but market dynamics will differ in the remaining geographic regions, where the balance of power among the state, hospitals, HMOs, and physicians is less favorable to the state.

The Political Environment

Pennsylvania's Medicaid administrators enjoy an unusually supportive political environment. Early in his administration, Governor Ridge embraced the notion of statewide mandatory managed care, and he made it clear to the state's top Medicaid officials that as long as they did their part, he would defend them to every extent possible against potential resistance from the legislature, the provider community, and interest groups. DPW's Medicaid administrators have worked successfully to maintain good relations with these constituencies.

For the most part, the legislature has been supportive of DPW's Medicaid policies, but as one official noted, OMAP works to keep its "ducks in a row," thereby heading off possible conflicts. This contrasts with other states, where Medicaid units located in welfare agencies are subject to relatively high levels of legislative scrutiny and criticism (Johnston, 2002). The politically astute DPW secretary has built and maintained good relations with the legislature, which recognizes that the governor has been solidly behind most of her policy decisions.

Another positive element of OMAP's political environment is good relations with other executive agencies. This is due partly to the DPW secretary's establishment of a "cabinet steering committee." This committee — which includes representatives of the executive agencies charged with budget, health, administrative, and legal policy, among others — serves as a mechanism to keep major actors apprised of OMAP activities, to avoid surprises, and to iron out policy conflicts.

A unique and important feature of the Pennsylvania Medicaid political environment is the role of the Pennsylvania

Health Law Project, or PHLP. PHLP is a powerful health advocacy agency that focuses on “civil health law for the poor” (www.phlp.org). A highly litigious organization, PHLP regularly brings suit over various health issues, including Medicaid and especially disability health services. Medicaid administrators interact regularly — and sometimes contentiously — with PHLP. For the most part, BMCO and OMAP officials have been very careful to pay close attention to PHLP and its objectives. In fact, the PCCM program — *Family Care Network* — grew out of a PHLP lawsuit over the state’s Early Periodic Screening, Diagnosis and Testing (EPSDT) program for child Medicaid enrollees. PHLP staffs the Consumer Subcommittee of the state’s Medical Assistance Advisory Committee, which represents patients and their needs. And PHLP was involved in creating an early CHIP model that preceded the federal CHIP.

PHLP forces OMAP to be responsive to patients and their needs. In the words of one Medicaid administrator, PHLP “keeps us on our toes.” Medicaid officials acknowledge that while PHLP’s scrutiny diverts management resources, it also prods the state to pay close attention to poverty health issues that might otherwise get short shrift. In addition, because of PHLP’s surveillance, OMAP and BMCO craft managed care policy and programs with the knowledge that lawsuits are likely. As a result, policy is vetted in order to minimize patient dissatisfaction and potential lawsuits.

The influence of PHLP is felt not only by the state, but also by the Medicaid managed care plans. HMO administrators indicate that PHLP’s careful attention to their performance encourages them to pay strict attention to the needs of their Medicaid enrollees. Thus, the political impact of PHLP can work in favor of the state’s position vis á vis the HMOs because of the HMOs’ need to be responsive to PHLP.

BMCO’s relations with Pennsylvania’s health care providers, including *HealthChoices* HMOs, hospitals, physicians, and others, are fairly positive, with finances as the “organizing principle.” The role of gubernatorial support is critical in this relationship.

Naturally, providers do complain about reimbursement rates, performance expectations, and other issues — officially to the legislature, and unofficially through various political channels — but Governor Ridge almost always supported the OMAP position.

Early in the *HealthChoices* program, Medicaid HMOs lost roughly \$25 million in Philadelphia alone. They lobbied the legislature to provide relief, but the governor refused their request. Because the HMOs and other providers had essentially “no traction” with the governor’s office, they recognize that they have limited power in the statehouse, that OMAP and BMCO have strong political support for their policies, and that those policies must be taken seriously. By comparison, providers in many states have real influence over legislatures, and can undermine the capacity of Medicaid managers to hold them accountable (Fossett et al., 2000).

Some of the more successful managed care states have used reorganizations to protect management from the political environment, often jump-starting Medicaid administrative systems by divorcing them from the heavily scrutinized welfare agencies in which they were traditionally housed. For example, Michigan created a new Department of Community Health with a great deal of fanfare (Weissert and Goggin, 2002); Colorado authorized a new Department of Health-Care Policy and Financing; and when Arizona launched its unique Medicaid program known as the Arizona Health-Care Cost Containment System (AHCCCS), it fashioned an entirely new organization — explicitly separate from the rest of state government.

This strategy proved to be unnecessary in Pennsylvania. But-tressed early on by a strong and supportive governor, and bolstered by the DPW secretary’s political and administrative skills, a “firewall” protects Medicaid managers and frees them to focus on critical policy and administrative issues. The PHLP is a powerful political interest that further reinforces an emphasis on program management and oversight.

While the Republican Ridge administration resisted provider appeals for financial and regulatory relief, one current concern is

that the new Democratic Rendell administration could face more pressure to meet provider demands in order to appear hospitable to business interests. In addition, *HealthChoices* has operated thus far in areas with large numbers of hospitals and physicians, and competition among these providers has enabled the state to push its policies. As *HealthChoices* moves into rural areas with fewer hospitals and physicians, it is likely that relations with these provider groups, most of whom are expected to resist managed care, will become more contentious and subject to political conflict.

The Market Environment

The Pennsylvania managed care market is characterized by strong competition and high HMO penetration rates. Substantial profits in the early 1990s attracted many HMOs to Medicaid managed care RFPs and to the commercial insurance market (Birnbaum, 1998). The highly competitive market has facilitated the task of Medicaid administrators. In general, Medicaid managed care RFPs generate multiple competing proposals. Each of the three existing mandatory areas is served by three HMOs. Overall, seven HMOs contract with the state, with some serving more than one region. Some HMOs were newly created to serve the Medicaid population, and others are Medicaid-only subsidiaries of existing commercial plans, some of which serve multiple states. One of the seven emerged from an original *HealthPass* plan in Philadelphia.

As noted above, the political environment limits the negotiating power for providers. This, combined with the competitive market, the high HMO penetration rate, and the fact that the state deals primarily with Medicaid-only HMOs that rely heavily on state business, puts OMAP and BMCO in an enviable purchasing position. Thus far, OMAP has also benefitted from the fact that *HealthChoices* operates in regions where state contracts are made more attractive by the Medicaid share of the insurance market, estimated at 50 percent in Philadelphia and 25 percent in Pittsburgh.

States use a variety of strategies to retain Medicaid plans and attract competing bids, often without much success. But with the

exception of its attention to the 35,000 enrollee base target, Pennsylvania has not needed these strategies to attract bids and retain plans. For instance, Pennsylvania does not require lock-in periods for HMO enrollees, and enrollees are free to change plans at any time. The fact that there is less than a 1 percent monthly change rate suggests that satisfaction is fairly high among enrollees. Many other states use auto-assignment to prop up plan enrollments. Like Michigan, Pennsylvania has used auto-assignment to reward good HMO performance, but it now configures auto-assignment to help the smaller plans. Yet only 15 percent of enrollees are assigned to HMOs automatically, and over 90 percent select their primary care physician.

One recent move designed to reduce administrative burdens on plans will set contract periods at five years, with options for three-year renewals. The state believes that this will help plans by reducing some of the uncertainty associated with the previous, shorter contract periods, and by decreasing the amount of resources that plans must devote to gearing up for new RFPs. However, annual rate negotiations will continue.

State administrators, in part because of their partnership approach with HMOs, have constructed a rate schedule that they believe — and that the plans admit — allows an adequate financial return. In a sense, the state has designed a system that facilitates HMO success, yet the market environment means that it retains substantial negotiating power over those plans that do succeed.

Managing Pennsylvania Medicaid Managed Care

Through aggressive recruitment and staff development strategies, Pennsylvania has assembled a first-class Medicaid management organization and an unusually successful program. By taking advantage of a favorable political and market environment, and building on a sound program design, the leaders of the state's Medicaid program have put together a successful contracting

process and an effective oversight system, while building and maintaining good relations with providers. Emphasizing health service quality, and continually building capacity in other oversight areas, OMAP — and especially BMCO — has developed a set of interdisciplinary Core Teams that form the hub of the program’s management system.

The comparative strength of Pennsylvania’s management capacity is evident from its success in attracting multiple bids on *HealthChoices* contracts and the retention of the interest of bidders over time. In addition, enrollees seem satisfied with the program, there are relatively low HMO enrollee turnover rates and low auto-assignment rates, and the Medicaid HMOs have a great deal of respect for OMAP and BMCO, despite being held to very high performance standards.

Leadership

From all accounts, Pennsylvania’s Medicaid management leadership is first rate. The overall Medicaid team is led by the DPW secretary, who is not a health policy professional, but has generalist management expertise and very good political skills. She has served in various top administrative positions in state and local government in Pennsylvania and other states, gaining extensive experience managing complex programs and interacting with legislative bodies and policymakers.

The combination of a supportive political environment and good managed care market conditions has facilitated recruitment at the top of OMAP’s management structure. The DPW secretary has been able to recruit and retain several very well-respected administrators, many of whom were attracted to the excitement of the new program, the opportunity to build a program with firm political support, and the chance to work with other talented managers on a team devoted to improving public policy. The hub of the management structure is formed by a health policy expert, a management expert, and a chief medical officer. These administrators have, in turn, built solid staffs characterized by a strong sense of

professional commitment and dedication to programmatic excellence. Providers who work with managers in other states endorse the Pennsylvania management team — and its leadership — as “one of the best.”

The Deputy Secretary for OMAP is a health policy expert from the nonprofit health community. Although she did not have managed care experience when she was recruited, she was well versed in the health care needs of low-income individuals and understood the advocacy organizations. She has been involved in *HealthChoices* from its early stages. The BMCO Director was recruited because of her excellent management skills. She joined OMAP from the welfare side of the DPW, and had little knowledge of Medicaid or managed care, but was known to be one of the most capable administrators in the agency. The Medical Director is a physician with strong policy and analytic skills; he is the quality control expert for OMAP, and his leadership is critical to OMAP’s and BMCO’s oversight of HMOs and other service providers.

Because of this exceptional managerial leadership, the state’s Medicaid managed care program is one of only a handful in the country that satisfies the conditions of prudent purchasing. These leaders communicate a clear sense of performance expectations to managed care contractors, oversee relatively sophisticated data collection and analysis to evaluate contractor performance, and have the standing and the willingness to reward and sanction performance.

Managing Managed Care: The Core Team Approach

A key feature of the state’s managed care management structure is the use of interdisciplinary work groups called Core Teams. The Core Team design is based on hospital interdisciplinary teams that bring a wide variety of skills such as financial management and clinical expertise to health services management. This matrix management approach, which was adopted by OMAP in the late 1990s, provides functional and geographic specialization for monitoring and oversight.

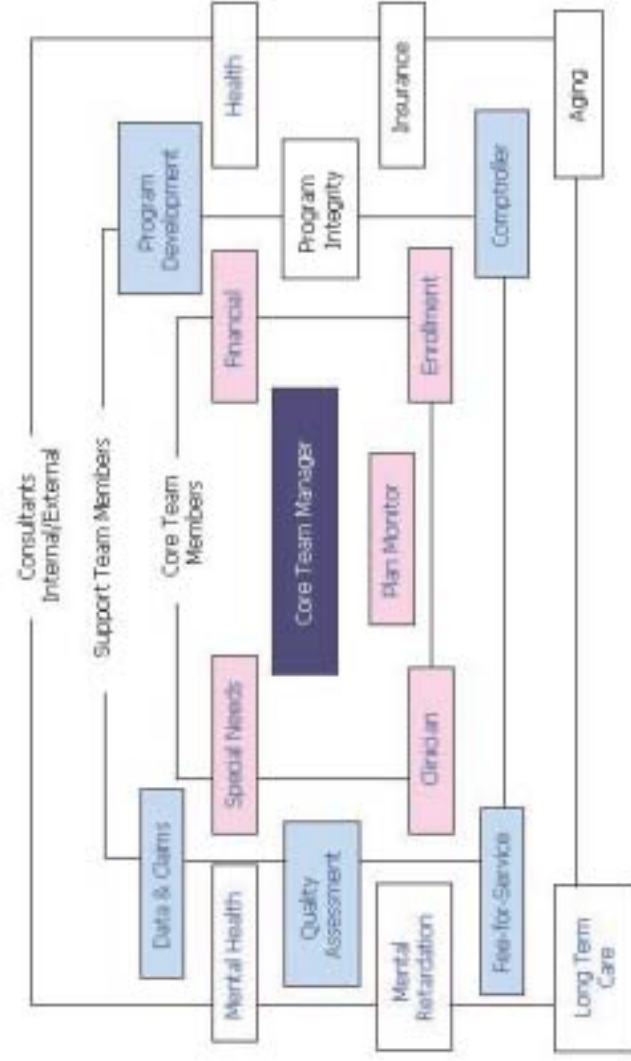
The bulk of the Core Team staff are located in the BMCO, which employs roughly 100 employees. Each Core Team is led by a Core Team manager, who together with a plan monitor, serves as the coordinate point for experts from three of BMCO's Divisions — Financial Analysis, Special Needs, and Enrollment Assistance Programs.⁶ (The Core Team managers and plan monitors are housed organizationally in BMCO's fourth division — Managed Care Operations Monitoring and Compliance.) Together with clinical staff from OMAP's Office of the Medical Director, the other key organizational component of the managed care oversight system, they form the "core" of the Core Team.

The "core" of the Core Team is bolstered by "support team members" from BMCO's *HealthChoices* Development and Support unit, which is charged with oversight of the contracting process, from OMAP bureaus that administer Data and Claims Management, Fee For Service Programs, and Program Integrity, and from the State Comptroller's office. Finally, a group of internal and external "consultants" advises the Core Team from other units either within OMAP and DPW, or from other state agencies responsible for mental health, services for the developmentally disabled, long-term care and aging services, and insurance administration.

Visually, the Core Team resembles concentric rings or squares with the Core Team manager and plan monitor at the center, surrounded by the four Core Team members, then encircled by the support team members, and enveloped finally by the internal and external consultants (see the illustration on page 16). Currently, Core Teams are charged with monitoring only *HealthChoices*, the full-risk managed care program. Oversight design for the PCCM and FFS programs is more traditional.

The BMCO divisions typically allocate part of one or more FTE staff to each Core Team. The Core Team member thus serves on the team, yet continues to report to the Division in which he or she is employed. For the most part, the Division supervisors who oversee the Core Team members work cooperatively with the Core Team to facilitate the matrix design. This collaboration extends also to members of the Core Team who work outside of the BMCO.

Core Team Structure



Each Core Team is responsible for monitoring one specific HMO, and each HMO deals with only one Core Team. Thus, a Core Team may oversee an HMO that serves more than one geographic region. The Core Team manager and plan monitor are rotated periodically so that they don't become too cozy with any single HMO. The Core Team Manager typically has one to two support staff, and coordinates a team that totals roughly a dozen individuals.

Like many other states, Pennsylvania relies on contractual consulting firms to enhance Medicaid management. Two firms with long-standing contracts provide specialized help to BMCO and the Core Teams: William Mercer advises BMCO's Division of Financial Analysis, and Tucker Allen consults with BMCO's *HealthChoices* Development and Support unit. These consulting contracts are administered directly by the directors of the BMCO divisions that use their services. Compared to other states, Pennsylvania appears to be fairly reliant on consulting contracts. While some states, such as Arizona and Ohio, make relatively little use of consultants, others such as Pennsylvania, Michigan, and North Carolina use them more extensively, and West Virginia delegates nearly all its Medicaid management functions to consultants (Johnston, 2002).⁷

BMCO's monitoring teams focus not only on contract compliance and performance, but also on building partnerships with the HMOs. Pennsylvania policymakers, like those in many other states, initially thought managed care was "all about procurement," but OMAP officials quickly recognized that managing managed care is in fact much more complex. Although the Core Team manager and plan monitor are the "go to" individuals for the HMO, there are relationships between the HMO's and BMCO's chief operating officers, finance directors, medical directors, etc. These "functional" relationships are critical elements of the matrix/Core Team design, and they generate much of the valuable informal information that helps BMCO stay on top of HMO problems.

To further facilitate the matrix design, the DPW secretary has emphasized an open policy process and constituent participation.

One structure used to broaden policy input is the *HealthChoices* Policy Board. This Board includes staff from both the physical and behavioral health HMOs — medical directors, managers, and support staff — as well as DPW’s secretary, senior policy officer, comptroller, chief counsel, chief medical officer, and chief psychiatric officer, and OMAP’s bureau directors, among others. Through this forum, and through other less formal structures, all middle managers in OMAP and related DPW units interact regularly. As described above, DPW also has a well-developed consumer input process through its Medical Assistance Advisory Committee.

Building and Maintaining Management Capacity for the Core Teams

Compared to most states, Pennsylvania has invested extensively in building Medicaid management capacity, and has had substantial success recruiting and developing a highly skilled management group. Medicaid agencies in other states have faced uphill battles in recruiting and training staff. The combination of limited resources, downward pressure on Medicaid spending, and the need for staff with skills not commonly found in the public sector has restricted the capacity of most states to build effective management organizations for Medicaid managed care (Johnston, 2002). Pennsylvania appears to be an exception. Like Arizona, it has been able to build a strong management team that has the skills required to satisfy the conditions of prudent purchasing. And although Pennsylvania’s Medicaid managers are constantly scrambling for resources for training and staff development, the fact remains that unlike most other states, they are able to find those resources and put them to good use.

Recruitment

For the most part, recruitment for BMCO and related quality control staff has occurred within state government, often from inside DPW, an agency that has historically attracted and retained well-qualified employees. Most BMCO staff above the

administrative support level have baccalaureate degrees, and many have master's degrees. Like Florida, Pennsylvania has been able to recruit in a capital region where government dominates the job market, where the population is relatively well educated, and where state salaries are considered attractive. Pennsylvania state government enjoys a remarkably low employee turnover rate — one of the lowest in the country (Barrett et al., 2001). This contrasts with other states with salaries considered too low to attract the skills required for effective Medicaid management (Johnston, 2002). Unlike many other states, Pennsylvania has not recruited staff from managed health care plans, despite some initial attempts to do so. And because most Medicaid HMOs are headquartered in the urban areas of the state, they have not raided government staffs until relatively recently, with the extension of *HealthChoices* to the capital area.

The BMCO Director recognized early in the process that “we needed a different kind of staff” to effectively manage managed care. Historically, Medicaid staff had focused on service authorization and relations with individual and institutional providers, and like Medicaid professionals in many other states, they were somewhat skeptical of the managed care concept and of the “partnership” approach to contracting. After deciding on the matrix management model, BMCO cast a wide net, trying to attract the “best brains” to build the Core Teams.

Like Michigan and some other states, Pennsylvania pushed the boundaries of civil service descriptions and created a new classification that attracted “new blood,” including professionals such as teachers who wanted a second career. This strategy, combined with capitalizing on a highly capable DPW staff, enabled the state to hire individuals from a wide range of backgrounds including social workers from government and the nonprofit sector, generalist social welfare professionals from the welfare and policy areas of DPW, and nurses from within DPW, from facilities for the developmentally disabled, and from the private sector. With the support of the state's executive leadership and the DPW Secretary, OMAP and the BMCO have built a management team that is, compared to

the rest of state government, relatively young, with several employees in their 20s and 30s.

Although the civil service system continues to constrain hiring to some extent, BMCO has thus far been able to attract and retain a highly competent staff. Some of the state's recruitment strategies were surprisingly simple — distributing flyers to area government and nonprofit agencies, for example — and others piggybacked on existing efforts, such as regular state recruitment visits at selected colleges and universities.

Staff Training and Development

Few of the current BMCO staff had managed care experience when they joined the organization. Team building and other staff development tools were used to prepare the Core Team managers and members. Investments were made to facilitate organizational transition and the ensuing cultural changes envisioned for the Core Team model. By comparison, most other states have devoted few resources to staff training and development (Johnston, 2002).

Several “tracks” of training and staff development were used to gear up for managed care — and for ongoing development. One track focuses on the Core Teams, with in-house training conducted by state specialists, and with specialized matrix management training conducted off-site. The Tucker Allen consultant group offers annual focused Core Team development sessions, often hosting leading national experts on matrix management. In addition, in most years, an intensive in-house two-day training session is conducted for the Core Teams on such topics as enrollment management, the Pennsylvania Health Law Project, and other relevant issues. Training and staff development for the Core Teams sometimes includes the BMCO Division directors who supervise the team members, in order to keep them abreast of Core Team work.

Another training track, known as the *HealthChoices Training Institute*, is conducted by BMCO's *HealthChoices* Development and Support unit. This training is ongoing, up to once or twice monthly, with short specialized sessions. Examples include a

lecture by a former chief executive officer of an HMO about “what makes a managed care organization tick.” Other speakers include experts on pharmacy management; on the basics of HEDIS, CAHPS, and other health measures; and the state’s physician general discussing tele-medicine. These training sessions are opened up to other OMAP bureaus, and they are well attended. Yet another track consists of annual executive training for top OMAP managers. Finally, all new BMCO employees receive bureau orientation training. Tuition reimbursement is also available to employees interested in completing degrees or continuing their education.

Efforts are made to maximize training opportunities, given limited funding. For example, BMCO has relied on Tucker Allen to contribute resources for sessions by leading national experts. The evidence suggests that these training and development investments have generated returns. OMAP administrators feel that the BMCO staff is very strong and came up to speed very quickly. For the most part, Medicaid staff — especially the Core Teams — are able to anticipate problems before the HMOs can, and are often able to at least cushion performance crises.

Managing the Contract and Implementation Process

The contract negotiation process is designed with the partnership model in mind. OMAP and BMCO recognized early on that most HMOs are skilled at enrollment management, claims processing, and to some extent, network building, but they didn’t necessarily know how to manage care for Medicaid recipients when they assumed their contracts with the state. Knowing they will have to work very closely with the plan, “teaching” along the way — especially about the unique needs of Medicaid patients — the state’s Medicaid officials are very careful about proposal selection. The proposal review process is based not only on the formal proposal, but also on how OMAP and the BMCO players “feel” about the proposal and the plan. The process is characterized as “much more complex than pure procurement.”

Pennsylvania does not use a competitive bid process but, typical of most states, follows an “any willing provider” approach. Proposals are reviewed within BMCO’s *HealthChoices* Development and Support unit by a multidisciplinary team, including Core Team members, led primarily by staff from throughout BMCO, OMAP, and DPW with expertise in financial and clinical/quality management, and supplemented by Tucker Allen.

BMCO and Tucker Allen initially identified 400 performance indicator “musts” to be incorporated into the HMO contracts in order to satisfy audit requirements. The Director of the BMCO integrated many of these performance indicators into BMCO’s customized desktop automated information system known as SMART. SMART is designed to generate instantaneous reports on many of these indicators, as well as *ad hoc* reports as needed. Over time, with input from providers, BMCO has streamlined the system, reducing the “musts” to 300, and changing some reporting schedules from quarterly to biannual or annual.

Relations with Providers

Relationships between HMO administrators and BMCO contract monitoring staff are facilitated by the state’s Core Team system, which strengthens professional exchange. Pennsylvania Medicaid officials characterize their monitoring style as very “hands on,” with the provider-state “partnership” in mind. Managed care plan administrators agree with this assessment, but they note that what distinguishes Pennsylvania is its ability to focus on the “important things.” BMCO underestimated how much daily “back and forth” communication with the plans would be required for effective monitoring, as well as the number and intensity of on-site visits. HMO managers note that while they may communicate less frequently with Medicaid administrators in other states, officials in those states often exhibit a more regulatory, micromanagement approach. According to Pennsylvania’s Medicaid HMOs, OMAP and BMCO managers hone in on the key issues and hold the plans’ “feet to the fire,” but they don’t tell plan managers “how to do our job.”

Plan administrators indicate that Pennsylvania's Medicaid managers are much better than most at understanding the needs of the plans — without caving into their demands. They describe relations with Medicaid administrators in other states as “more tense, more delicate, and more distant.” Asked to describe Pennsylvania's managers to those in other states, they use words such as “exceptional,” “impressive,” “sophisticated,” “outstanding,” and “excellent.” They share the state's view of the provider-state relationship as a “partnership.” Plan officials note that Medicaid administrators will “hit you in the head if you screw up,” but they will also “help you avoid getting hit again.” Medicaid officials won't “surprise” you, and “when you're right, they'll stand with you.”

According to the plans, Pennsylvania's Medicaid managers collect “enormous amount of information,” and unlike those in some other states, “they pay attention to it,” watching the plans very closely. However, the relatively open state-provider relationship leads to substantial information exchange, although plan managers note that they'd always like more information from the state, especially with regard to the actuarial data used to set rates.

The recent weak economy has generated some strains with hospitals and other institutional providers. These providers have exhibited significantly more “grouchiness and stress,” sometimes threatening to withdraw from their contracts with HMOs. For the most part, these threats have been resolved and parties have typically reached agreement with relatively few provider losses. In a few cases, however, litigation over HMO subcontracts have drawn the state into court. This more difficult dynamic could be exacerbated by rate negotiations in the coming year or two, and state budget constraints will put serious pressure on state rate adjustments.

But for the most part, plan managers trust the Medicaid administrators to live up to their word, and to keep them apprised of problems. BMCO's command of the program, together with its keen insights into provider strengths and weaknesses, engenders substantial respect from plan administrators, and enhances the state's position in the state-provider relationship.

Rates

Reimbursement rates are not standard across plans, but are adjusted to account for geographic and other cost factors. While Medicaid officials characterize reimbursement rates as low, modifications have been targeted at those service areas perceived as limiting access to care, and while HMO officials of course agree that the rates are low, they describe them as sufficient for financial success.

Rates are renegotiated annually. Although feedback from HMOs is considered in the rate-setting process, the state “doesn’t give much.” The governor and legislature “don’t cave” in the face of HMO complaints about rates, and by the time the draft rates have been released to the HMOs, the Secretary’s cabinet steering committee has signed off on the rate schedule. In effect, the plans “have nowhere to go” if they are dissatisfied with the state’s proposed rates.

BMCO is becoming increasingly involved in risk adjustment. After extensive research based on other states’ experiences, academic studies, and professional exchange, BMCO has created a risk-adjustment steering group and has begun the process of fine-tuning the risk adjustment process. The objective is to more closely align reimbursements with costs to reduce the probability of adverse selection — i.e., the incentive for HMOs to enroll mostly healthy individuals while avoiding sicker, more needy patients.

Managing Quality Control

One of Pennsylvania’s Medicaid managed care strengths is its quality control component. Like most states, Pennsylvania devotes substantial resources to quality management, and this component of oversight is better developed than the systems that review financial, utilization, and other performance categories (Fossett et al., 2000; Johnston, 2002).

OMAP’s Medical Director is responsible for quality control and for related programmatic and policy issues. He oversees two

units with approximately 25 staff — a Clinical, Operations, and Policy Section and a Quality Assessment Section. In addition to service quality oversight, these units also monitor utilization, access to care, and some special needs services. Recruitment in this more technical part of the organization has been somewhat more difficult than in BMCO. Most of the staff have training in some clinical field — especially nursing — or in information/data management. The Medical Director’s staff reports to him, but also to relevant Core Teams to comply with the BMCO matrix management model.

A variety of clinical performance measures is used to oversee quality performance, including HEDIS, CAHPS, and others. These measures are used to generate relatively comprehensive internal and public reports, including an extensive “report card.” Because of the competitive HMO environment, plans “hate being in last place” on these report cards, and they consequently strive to improve their performance. On-site quality monitoring reviews are performed regularly by the Core Team manager, plan monitor, and representatives of the Core Team. In addition to HEDIS, CAHPS, and some other customized performance measures, BMCO staff is relying increasingly on encounter data to monitor service quality, as well as to adjust rates.

While Pennsylvania is relatively strong in terms of data analysis, Medicaid officials continue to seek improvements and additional staff to strengthen their analytic capacity. Nonetheless, BMCO’s internal quality reports are comparatively sophisticated, with extensive across-plan analysis of multiple health and other performance indicators. Like other states, OMAP relies primarily on descriptive data analysis, although it does include some trend analysis and some testing to determine whether changes in performance are statistically significant. Studies of information management and analysis in other states suggest that Pennsylvania is far ahead of most of the country (Goggin, 2002), and a review of performance management reports reveals improved report quality and complexity over time.

Related Program Monitoring

BMCO relies on three primary sources of program performance information — financial reporting, the clinical measures including HEDIS and CAHPS, and encounter data. These “triangulated” streams are used to review not only service quality, but also access, utilization, satisfaction, and financial performance.

Pennsylvania’s state government has a talented financial management team (Barrett et al., 2001), and Medicaid financial managers are no exception. The state used its Medicaid Upper Payment Limit (UPL) to generate nearly \$400 million in federal matching dollars for nursing homes — effectively increasing its FMAP from 54 percent to 65 percent in 2000 (Coughlin and Zuckerman, 2002; U.S. GAO, 2002).

For financial monitoring, each Core Team includes an accountant charged with collecting, analyzing, and reporting HMO financial performance information. A wide variety of financial measures is analyzed comparatively across plans, including HMO market shares, operating margins, profit ratios, equity reports, and cost structures. The Core Team manager and plan monitor closely scrutinize these reports, combining them with information from the Office of the Medical Director about such factors as chronic disease prevalence in the HMO’s enrollee population, and more general demographic information including the need for language translation, enrollment and disenrollment patterns, etc. The Core Team manager therefore serves as the point at which information is combined to provide a comprehensive view of HMO performance.

As in all functional monitoring areas, however, there is a great deal of interchange between specialized professionals within BMCO and their counterparts in the HMOs. BMCO’s financial managers interact regularly with HMO financial staff and, compared to their counterparts in other states, they have a relatively clear understanding of HMO performance — financial and otherwise. For example, the BMCO recognized the danger signs warning of a recent financial crisis in one of the HMOs. They anticipated

the crisis before the HMO's financial leaders did, and were therefore able to mitigate some of the programmatic consequences. Nonetheless, BMCO leaders see financial management as another area in which they must strive for more rigorous analysis. One current problem is turnover in BMCO's financial staff. The William Mercer contract for actuarial analysis and rate development helps, but more in-house managed care financial experts are needed. Despite the state's scrutiny of their financial performance, HMO officials note that BMCO's financial analysis is exceptionally comprehensive, and often quite helpful.

The Core Teams, together with the Office of the Medical Director, monitor provider networks. BMCO and the Office of the Medical Director oversee access and utilization performance through their quality control processes, relying on a variety of clinical and satisfaction measures. Some of these are provided through the EQRO, and others flow directly from the plans to the state.

To summarize, the monitoring process is intensive and, according to BMCO, "very demanding." But the state's Medicaid managers believe that this intensity is necessary to maintain the partnership model, and to strengthen performance. The relationship between the state and the plans — a far cry from the idealized "arm's length" transaction style envisioned by privatization advocates — is more collaborative than a pure purchasing model would allow (Sclar, 2000; Kettl, 1993). Nonetheless, both parties to these contracts — the state and the Medicaid managed care plans — agree that the hands-off approach can't work for this type of program, and they are committed to an oversight process that requires extensive and ongoing dialogue.

Lessons For Other States?

The Pennsylvania case offers many insights into effective Medicaid managed care administration. What is clear is that the importance of management capacity does transfer to other states. More effective recruitment, training, and structural arrangements serve to strengthen management capacity and enhance program

performance. Thus, states that choose to devote more resources to program management, all else equal, are more likely to formulate better policies and to deliver higher quality services (Coggburn and Schneider, 2003, Donahue, Selden, and Ingraham, 2000; Heinrich and Lynn, 2000; O'Toole and Meier, 1999).

For example, the Pennsylvania matrix management model — the interdisciplinary Core Teams concept — is one that could be emulated elsewhere, and it clearly offers many advantages. The Core Teams draw from a wide range of expertise, and they facilitate communication and professional exchange within the state's management structure and across organizational boundaries with staff in the Medicaid HMOs that contract with the state. Pennsylvania's winning combination of recruitment and training, and a program design that fits the state's unique conditions, also suggest strategies that could improve management capacity in other states.

Yet the extent to which these insights can be used to improve administration in other states is not entirely evident. Despite the lessons we can draw from the Pennsylvania management story, the fact remains that much of its success hinges on its uniquely favorable management environment. Studies of Medicaid management organizations in other states strongly suggest that as much as management matters, the environment may be even more essential to program and policy success (Fossett et al., 2000; Johnston, 2000). Whether managers are freed from political conflicts to focus resources on program and policy, the extent to which administrators can maintain purchasing power vis á vis Medicaid managed care contractors — these are also crucially important factors that help determine whether a state runs a successful program.

Concerns about the future of Pennsylvania's *HealthChoices* program stem from anticipated changes in the political and market environment that currently benefit state managers. BMCO has profited from an enviable position as a managed care purchaser — one that has been fortified by political support from an administration willing to fend off provider pressures and by reimbursement rates that sustain an adequate level of competition among potential managed care organizations. The incoming Democratic

Rendell administration may feel compelled to turn a more hospitable face to provider interests in order to strengthen its relationship with the business community. And the severe budget crises that will plague the crop of governors taking office in early 2003 will have an impact on Pennsylvania, and on the extent to which it can support managed care rate enhancements.

Nonetheless, the Pennsylvania experience demonstrates that when the Medicaid management environment is favorable, a well-designed management system puts the icing on the cake and can push the program and policy toward excellence. The ability to attract and retain talented staff and the capacity to capitalize on advantageous environmental conditions appear to be critical elements in states with the most successful programs. In these states, managers are prudent purchasers, and their decisions lead to effective programs that maximize health benefits to Medicaid recipients.

Endnotes

- 1 The information used for this report relies on interviews conducted with Pennsylvania Medicaid officials and selected Medicaid HMO administrators. Most of these interviews took place in September and October of 2002, and the report reflects the program at that time. In addition, a wide variety of Pennsylvania Medicaid managed care documents were reviewed to supplement the personal interviews. Most of the comparisons of Pennsylvania's Medicaid management system to those in other states rely on research conducted as part of the Rockefeller Institute of Government's State Capacity Study, especially the work of Fossett et al (2002), Goggin (2002), and Johnston (2002), which analyze Medicaid management across ten states: Arizona, Colorado, Florida, Georgia, Kansas, Michigan, New Jersey, North Carolina, Ohio, and West Virginia. See www.rockinst.org.
- 2 Governor Ridge resigned to join the Bush Administration in 2000, and Republican Governor Mark Schweiker filled the remaining two years of Ridge's term.
- 3 See Appendix 2 for a list of acronyms.
- 4 Unsuitable designs are not necessarily independent of the political and market environments. For instance, in some states, such as

Kansas and West Virginia, political pressures resulted in statewide mandatory full-risk, one-size-fits-all managed care programs that faced huge barriers to success in rural areas. Other states, such as Georgia, tried the full-risk model but had to abandon it because that design was doomed in a state with a very low commercial managed care penetration rate.

- 5 Pennsylvania's managed care program "carved out" mental health services, but unlike many other states, delved into mandatory mental health managed care comparatively early in the process. Pennsylvania issues separate RFPs for its distinct "behavioral health" component in the three *HealthChoices* regions. (Contracts for general managed care services are referred to as "physical health" contracts). Although the physical health HMOs fought to include behavioral health in their contracts because of the potential profit, the state insisted on separate providers for the behavioral health contracts.
- 6 The fact that BMCO dedicates a division to special needs attests to the state's commitment to highlighting special needs services.
- 7 Like most states, Pennsylvania also contracts for some enrollment services, and as mandated, with an External Quality Review Organization for periodic quality reviews.

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Appendix Acronyms

BMCO	Bureau of Managed Care Operations. Administers Pennsylvania's Medicaid managed care programs.
CAHPS	Consumer Assessment of Health Plans Study. Used to evaluate Medicaid managed care programs in states.
CHIP	Child Health Insurance Program. Federal-state program for low- to middle-income children without health insurance.
DPW	Department of Public Welfare. Administers Pennsylvania's social welfare and health programs.
FFS	Fee for Service
HEDIS	Health Plan Employer Data Information Set. Used to evaluate managed care programs.
HMO	Health Maintenance Organization
OMAP	Office of Medical Assistance Programs. Administers Pennsylvania's Medicaid Programs.
PCCM	Primary Care Case Management. Type of Medicaid managed care program.
PHLP	Pennsylvania Health Law Project. Health advocacy organization.
SNU	Special Needs Unit. Units established to deal with special health care need patients. Required in Pennsylvania's contracts with Medicaid managed care HMOs.



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