



The LEWIN GROUP

Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program

Prepared for:

**Coalition of Medical Assistance Managed Care
Organizations**

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EXECUTIVE SUMMARY

A. Introduction and Background

HealthChoices – the Commonwealth of Pennsylvania’s mandatory capitated managed care program for Medical Assistance (MA) recipients – was implemented using a zone phase-in schedule beginning in 1997. The program is now mandatory in three zones: the Southeast Zone, Southwest Zone, and Lehigh/Capital Zone. In the remaining counties, members receive services through a fee-for-service program or through a voluntary capitated managed care program.

In 2003, in a major policy shift, the Pennsylvania Department of Public Welfare (DPW) terminated the planned statewide expansion of the HealthChoices program. In early March of 2005, Pennsylvania began phasing in its new ACCESS Plus program, an enhanced primary care case management (EPCCM) program, in the counties without mandatory capitated managed care, including those previously scheduled for HealthChoices expansion.

The Pennsylvania Coalition of Medical Assistance Managed Care Organizations (the Coalition) was formed by the seven physical health managed care organizations that contract with the Commonwealth of Pennsylvania to provide services to recipients enrolled in the HealthChoices program. Given the state’s recent policy reversal and the fact that, like most other states, Pennsylvania continues to seek out options for reducing expenditures and gaining efficiencies, the Coalition desired an independent assessment of the value of the HealthChoices Physical Health Program to help inform the continuing debate about the future direction of the state’s Medical Assistance program. Toward this end, the Coalition commissioned The Lewin Group to conduct a comparative evaluation of Pennsylvania’s HealthChoices Program and Fee-for-Service Program, focusing on four areas that contribute to a health care program’s overall value: its cost-effectiveness, its impact on access, the quality of services provided, and the program’s focus on and approaches to serving individuals with special needs.

The remainder of this Executive Summary summarizes the approach The Lewin Group employed to assess the issues involved and the key findings arising from our assessment.

B. Summary of Approach

To conduct this evaluation, Lewin met with each of the seven managed care organizations participating in HealthChoices to fully understand their programs; interviewed advocates to gain their perspective on the HealthChoices Program; and spoke with staff at Pennsylvania’s Department of Public Welfare to understand the current Fee-for-Service Program and plans under ACCESS Plus. In addition, Lewin reviewed and assessed available relevant data from both the Fee-for-Service and HealthChoices programs, as well as from other state Medicaid programs.

We should note that comparisons of HealthChoices to both the traditional Fee-for-Service Program in Pennsylvania *and* the recently implemented ACCESS Plus program are relevant to this assessment and are addressed in our report. Since ACCESS Plus, as yet, has no track record, much of our analysis of this program’s impact on cost, access, and quality, and its

special needs focus, involved a review of the program’s contractual requirements. In addition, we reviewed available information and outcomes associated with similar programs (most also in their embryonic stages) that have been implemented in other states. Finally, we considered the cost containment techniques and other attributes of enhanced Primary Care Case Management models and projected the potential performance of the model based on these attributes.

C. Summary of Findings

1. General Findings

HealthChoices is a highly successful program that appears to be working remarkably well for all stakeholders and to be delivering on all fronts:

- For the state, HealthChoices has delivered massive savings, and the level of savings continues to compound upwards as the health plans hold down the rate of cost escalation. Administrative costs are consuming a low percentage of revenues, yet the health plans are providing a compelling array of educational, outreach and other tailored initiatives within their administrative budgets (in addition to providing all the “routine” functions such as claims processing and payment). HealthChoices has enabled Pennsylvania to stand apart from most other Medicaid programs in recent years and preserve the Medicaid program’s eligibility, benefits, and provider payment levels.
- Medical Assistance recipients, in turn, have benefited from HealthChoices’ financial success, as over the past several years they have not been subject to the tightening of eligibility requirements or repeated new benefit restrictions that Medicaid recipients in numerous other states have suffered. In addition, the program is far superior to traditional Fee-for-Service programs in the areas of access, quality, and focus on special needs. Further, given the weaker cost containment attributes and contractual requirements of the ACCESS Plus program, we see ACCESS Plus as being incapable of achieving the same degree of health care improvements for recipients as have been accomplished by HealthChoices.
- The HealthChoices managed care organizations themselves represent financially viable health plans that, for the most part, are entirely tailored to the Medical Assistance populations they serve. Collectively, they employ hundreds of committed staff whose interest in serving this population is genuine and strong. We were struck in our site visits not only by the level of staff commitment to performing their jobs well, but also by the amount of personal time and resources the health plans’ employees devote to help the communities and individuals the health plans serve.

In short, what the HealthChoices managed care organizations provide in the way of outreach, access facilitation, innovation, cost-effective care, and enhanced quality is quite remarkable. It is important that the added value they bring to the Medical Assistance program become better understood by the policymaking community (and perhaps even by the broader population), which often seems to hear only negative stereotypes about the HMO coverage model. For those unfamiliar with the best of what Medicaid managed care has to offer, Medicaid health plans are often viewed as “insurance companies” and little more. The information presented in this

report reveals the much broader role the HealthChoices managed care organizations play and should provide convincing evidence that, in many ways, DPW and its contracting health plans have achieved an ideal public/private partnership.

2. Cost-Effectiveness

HealthChoices has performed exceedingly well financially, serving as a national model. If national policymakers were to create a list of key desired financial outcomes from a Medicaid managed care initiative, the HealthChoices program has delivered on all aspects:

- Consistently, the HealthChoices managed care organizations have done well at controlling rates of medical cost escalation, collectively holding average annual medical cost escalation to 7.4 percent over the past several years, compared to an average annual cost escalation of 10.4 percent in the Fee-for-Service Program. Further, the fee-for-service areas are largely rural, while the HealthChoices regions are more urban, i.e., the lower HealthChoices inflationary trend is on a higher cost platform, making the overall financial impact even more significant. Based on our analysis of the data, it appears that HealthChoices has saved the Commonwealth more than \$2.7 billion over the last five years.
- Year after year, the financial status of the program has been in exceptional balance. DPW's rate-setting efforts and the health plans' operational performance have both been exemplary when contrasted with capitated managed care programs in several other states. A number of states have seen health plans exiting the Medicaid program due to inadequate rates; in other states, where health plans are retaining an inordinate portion of their capitation revenue for administration and profit, it is a virtual certainty that the Medicaid program has been losing rather than saving money under their capitated managed care programs. In Pennsylvania, however, the collective medical loss ratio (medical costs as a percentage of revenue) of the HealthChoices health plans is approaching 90 percent, and while there is some variability in operating margin across plans, in the aggregate the health plans are holding administrative costs to approximately eight percent of revenue and achieving an operating margin of about three percent.
- Importantly, the cost-effectiveness that is occurring under HealthChoices is predominantly attributable to coordination of care. The HealthChoices program has served as a vehicle for propping up – rather than ratcheting down or discounting – unit prices paid to safety net providers vis-à-vis Medical Assistance fee-for-service rates.

It is difficult to provide an exact figure that represents the cost savings the HealthChoices program has achieved over the past several years. In the Philadelphia region, there has been mandatory Medicaid managed care (and thus virtually no Fee-for-Service Program) for close to two decades, and in all other HealthChoices regions it is also impossible to accurately estimate what Medical Assistance program costs would be if the fee-for-service model were still operating. However, given that state capitation programs generally seek approximately a five percent savings at the outset and that the slope of medical cost increases in HealthChoices have been very different than in fee-for-service, it is almost inconceivable that the state is not saving at least 10 percent and perhaps as much as 20 percent as a result of HealthChoices. Each

percentage point savings created by HealthChoices is currently worth more than \$35 million annually. If we assume HealthChoices costs are 15 percent below what the Fee-for-Service Program would expend in the Southeast Zone and 10 percent below fee-for-service in the other two zones (due to having been in place for fewer years), aggregate savings across the 5-year period 2000-2004 exceed \$2.7 billion.

3. Access

As has become increasingly apparent over the past several decades, financial coverage alone does not ensure true access to needed health and medical services. Access to and receipt of needed care by Medicaid recipients is affected by a plethora of factors, including but not limited to the following:

- **Level of active physician participation in the Medicaid program.** Low payments have been a longstanding issue in many states' Medicaid programs and have clearly dampened doctors' willingness to treat Medicaid beneficiaries.
- **Ease with which the Medicaid recipient can locate a physician who participates in Medicaid and whose panel is open to new patients.** Traditional Medicaid FFS programs often do not provide assistance to recipients in finding physicians who accept Medicaid. All too often, the approach is effectively one of "Here's your Medicaid card, have at it."
- **Proximity, appointment availability, and other "ease of accessibility" factors.** Geographic location, physical structure, convenience of office hours, and appointment waiting times are generally more important indicators of access than is the size of the provider network.
- **The degree to which cultural, language, and other barriers exist and the extent to which the recipient's health care coverage system addresses them.** Medicaid recipients often face significant cultural, language, socioeconomic, and psychosocial barriers to accessing health care. The structure of the individual's health care coverage system, i.e., whether it includes enabling services and other mechanisms for addressing these barriers is a key determinant of access to and appropriate utilization of services.

In conducting this study, The Lewin Group looked at access along each of its components. For each model (traditional fee-for-service, ACCESS Plus, HealthChoices), we assessed what the Medical Assistance recipient experiences at each point of potential interaction with the delivery system: What assistance with access occurs at the point of obtaining coverage? At the point of seeking care? What outreach and education occurs to inform and *assist* Medical Assistance members regarding the appropriate use of a health care system that seeks to coordinated their care? In obtaining preventive services and engaging in healthy lifestyles? Along all of these dimensions, we concluded that the HealthChoices program is engaging in both significantly more and far superior access-enhancing initiatives than can possibly occur under any type of fee-for-service model. The following are just a few examples of how the HealthChoices program improves access for Medical Assistance recipients:

- **The HealthChoices managed care organizations enhance active provider participation** through provider payment practices and initiatives; regularly performing and acting upon provider network analyses; cultivating relationships with providers through fully staffed provider relations departments, training and education, and assisting physicians in ensuring their panels receive needed services (through, for example, listing of members with certain diseases who are behind schedule with medication refills, medical screenings, etc.).
- **The managed care organizations help recipients locate network providers** through comprehensive provider directories that are available in alternative formats and made available to all members at time of enrollment and annually thereafter, with updates as needed; and through the operation of 24-hour member hotlines.
- **The HealthChoices managed care organizations incorporate scheduling and other “ease of access” network standards** that are much more specific than those imposed on the ACCESS Plus program.
- **The HealthChoices managed care organizations engage in a vast array of value-added services and initiatives designed to enhance access**, including member incentive programs to encourage use of preventive services and healthy behaviors; health education materials and approaches such as health screening reminder postcards; and calls from member services representatives to members who are being discharged from a hospital to assess whether the members are receiving services such as home health, durable medical equipment, or physical therapy.
- **The HealthChoices managed care organizations – as well as their individual employees – have undertaken numerous initiatives to invest in the communities in which their members live.** While not neatly categorized as “access-enhancing,” these activities support the managed care organizations’ efforts to empower members by showing that “someone cares about them.”

4. Quality

Several of the HealthChoices managed care organizations suggested that our assessment of quality incorporate comparisons of HealthChoices quality outcomes with Fee-for-Service Program quality results. Therein lies the crux of a key problem with the fee-for-service model. While HealthChoices is a *system* of care that was designed to incorporate strong quality management and improvement strategies, and which lends itself to quality measurement, the traditional fee-for-service model was neither designed nor is it a system. Quality measurement in the fee-for-service setting is exceedingly difficult; if quality cannot be measured well, improving it is that much more challenging.

Recent studies have reported that a general focus on quality and quality monitoring also are far less integral components of the Primary Care Case Management model compared to the capitated health plan model. The majority of Medicaid Primary Care Case Management programs are not yet using the quality measurement, feedback, and improvement strategies that are often required of capitated managed care organizations. While the ACCESS Plus program builds in numerous quality-related requirements, they are not as extensive as the HealthChoices requirements, nor does the structure of the Primary Care Case Management

program support quality measurement and improvements as well as does the integrated system of care embodied by HealthChoices.

That being said, our quality assessment focused by necessity on the HealthChoices health plans' accomplishments. One area of focus was the health plans' quality standing relative to their peers in the industry. On this dimension, the performance of the HealthChoices managed care organizations has been exemplary. Each of the HealthChoices managed care organizations is accredited by the National Committee for Quality Assurance (NCQA), a private, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans. NCQA evaluates health care in three different ways: through accreditation (a rigorous on-site review of key clinical and administrative processes); through HEDIS (a tool used to measure performance in key areas such as immunization and mammography screening rates); and through a comprehensive member satisfaction survey.

Six of the plans participating in HealthChoices are accredited with an "excellent" rating, one with a "commendable" rating. These are the two highest ratings for NCQA accreditation. To be awarded either the "commendable" or "excellent" rating, plans must demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. The "excellent" outcome (NCQA's highest) is awarded to plans that have also achieved HEDIS results that are in the highest range of national or regional performance.

The HealthChoices managed care organizations have several years of experience in monitoring performance and developing quality improvement initiatives. Each health plan has a quality improvement work plan in place, which includes their objectives for quality-focused work and guidelines for development of studies to address specific quality issues. Each has made significant investments in their quality programs, both to implement them and to track the results that are occurring. The health plans have convened numerous quality committees focused, for instance, on pediatric care, women's health, diabetes, asthma, and HIV. These committees work to coordinate quality related efforts across the health plan and consist of multidisciplinary groups of practitioners and interdepartmental health plan representatives. One health plan reports having 75 to 100 providers actively participating in one of the committees at any one time.

Each of the health plans also makes a serious investment in monitoring the results of their quality improvement initiatives. The objective is to identify initiatives that are having the most beneficial impacts so that these approaches can be continued and perhaps expanded, as well as to limit resource commitments to programs that are not producing desired improvements. This zest for continual and intensive self-evaluation was a common theme across the seven managed care organizations. The health plans strive to provide high quality care for their members, and their enthusiasm about self-evaluation extends far beyond the DPW requirements for quality initiatives and data reporting.

5. *Serving Individuals with Special Needs*

The integrated care coordination systems the HealthChoices managed care organizations have created significantly enhance access and quality for special needs individuals, most of whom under the unmanaged fee-for-service model are left on their own to navigate a disconnected

array of services that in no way resembles a “system” of care. Our conclusions are based on a review of key program components that are necessary to effectively serve special needs populations (outlined below) and the degree to which each of these components exists in the Pennsylvania Medical Assistance program’s various settings:

- **Activities geared toward identifying individuals with special needs and the specific nature of their needs.** The HealthChoices managed care organizations employ a number of mechanisms to identify, at time of initial enrollment and on an ongoing basis throughout the member’s enrollment, special needs (both medical and non-medical) that must be addressed in order to effectively serve them. They perform initial health assessments upon a recipient’s enrollment and regularly analyze pharmacy data, other claims data, hospital admission reports, member hotline call data, and other information to assist them in identifying and coordinating care for members with special needs. As is intended under the ACCESS Plus program, another method by which members with special needs are identified in the HealthChoices program is via member self-referral and referral from providers. In addition, however, the integrated infrastructure of the managed care organizations results in additional means of identification. For instance, utilization management nurses, pharmacy technicians, and member services representatives often become aware of a member’s special needs during member contact and/or standard utilization review.
- **Care coordination and case management approaches used to address both the health and social issues and needs of these individuals, including the development and implementation of individualized care plans.** The HealthChoices managed care organizations’ care coordination programs are multifaceted, serving members with a wide range of care needs and coordinating services and care across multiple providers. The health plans have established infrastructures and dedicated substantial resources to coordinate care for members with special health care needs. For example, all health plans operate a special needs unit (SNU) as required by DPW, which coordinates care between primary and specialty services, health education, and other human service systems needed by the member. HealthChoices health plans also have made substantial investments in care coordination activities outside of the SNU in separate care coordination units. When care coordination is provided outside the SNU, care coordinators work in close consultation with SNU staff as well as disease management staff. The health plans’ investment in care coordination is demonstrated in their robust staffing and infrastructure. Finally, the model of care coordination employed by the health plans is more than medical case management; the care coordination programs also assist members in accessing social service programs such as housing and food assistance, transportation, and child care.
- **Disease management (DM) initiatives undertaken to provide a system of coordinated health care interventions and communications for population subsets with specific chronic conditions.** Each of the HealthChoices managed care organizations operates a number of disease management programs, either internally, through external DM vendors, or both. They conduct disease management in the disease categories targeted in the ACCESS Plus program, as well as offer disease management for a variety of other conditions. For the managed care organizations, DM programs do not *replace* their individualized case management approaches, but rather serve as one component of that approach. Given the populations they serve, the health plans recognize that many

members who can benefit from a disease management approach will also still have present a number of psychosocial issues, as well as comorbidities, that will require specialized care management tailored to meet each individual's specific and special health care needs.

D. Concluding Observations

A great number of improvements can be made to the unmanaged fee-for-service setting through "enhanced primary care case management" arrangements such as the ACCESS Plus program, and in our view ACCESS Plus appears to be well-designed. At the same time, it is important to draw appropriate distinctions between what can occur under the managed fee-for-service environment versus the capitated HealthChoices model. Many aspects of the HealthChoices model simply cannot be replicated under ACCESS Plus or other managed fee-for-service approaches. These aspects are briefly delineated below.

Full Risk. The motivation that capitated managed care organizations have to contain costs cannot be matched in a fee-for-service payment structure. Managed fee-for-service models such as ACCESS Plus can provide important financial incentives to the contractors (and ACCESS Plus does this), but these arrangements cannot approach the dollar-for-dollar risk and cost management incentives that capitation creates. The costs savings attained in Pennsylvania are indicative of the positive results that can be achieved from full risk capitation.

Integration. Capitation contracting creates a highly integrated system of care in which the contracting health plans are responsible for access, delivery, and payment of a comprehensive array of acute care services. Although mental health, non-emergency transportation, and long-term care services are not included in the capitated benefits package, the HealthChoices managed care organizations have wide-ranging responsibilities. While combining disease management and primary care case management under ACCESS Plus creates a much more integrated system than does the traditional fee-for-service coverage model, this approach still does not offer nearly as high a level of integration as the capitated HealthChoices model. Under HealthChoices, the managed care organization is simultaneously concerned with a wide range of issues including an enrollee's environmental circumstances, health needs, level of awareness and access barriers, usage habits, medication mix, comorbidities, etc. The integrated model is bolstered considerably by the fact that the managed care organizations pay various providers throughout the acute care system for the services rendered. Providers need to interact constructively with HealthChoices managed care organizations in order to obtain payment. DPW's primary care case management and disease management contractors under ACCESS Plus do not serve as a payer and thus play a much more tangential role in their relationships with the provider community.

Competition. Managed fee-for-service programs such as ACCESS Plus are typically "given" an enrollee population to work with. The selected vendors do go through a significant competitive procurement to be awarded the contract, but face no meaningful competition for patients thereafter. In contrast, HealthChoices managed care organizations compete for business both at the point of bidding for a DPW contract and on a daily basis thereafter. This ongoing competition appears to be creating dynamics where the managed care organizations are continually striving to attract and retain enrollees, and to be perceived as the organization that provides the best service to the beneficiary population.

Local Focus. One challenge that fee-for-service based models face is getting anywhere near as “local” as the managed care organizations are able to. To a large degree, the HealthChoices managed care organizations employ staff who live in the communities being served and who have a strong knowledge of and commitment to these communities. The ongoing presence of HealthChoices staff at local provider sites, community events, shelters, and members’ homes, for instance, is an important and unique advantage of the capitated model. In contrast, Medicaid fee-for-service models tend to rely primarily on staff working out of a state’s capital city, and/or on contractors whose staff may often predominantly work from out-of-state locations.

Innovation. The fee-for-service coverage model – even when it is significantly enhanced such as through the ACCESS Plus initiative in Pennsylvania – is ill-equipped to go “outside the box” to achieve a positive result. For example, provider-specific investments, such as paying a selected primary care provider to extend its office hours, can much more readily occur in the capitated setting than in the fee-for-service environment. Similarly, a HealthChoices enrollee can receive a special benefit (e.g., housing support) from a health plan that believes its investment will be more than offset by lower health care costs. Capitated health plans can implement a wide range of “spend to save” investments in the capitated setting that simply cannot occur within the fee-for-service model.

Politics. The Medicaid fee-for-service program presents a visible target for provider associations and other groups with vested interests who wish to secure higher funding levels for their constituents. The more care that occurs through the fee-for-service setting, the stronger the opportunity of the lobbying interests to work for preferential treatment. Under HealthChoices, it is certainly still possible for organizations to press for legislation to achieve a certain desired outcome (e.g., “carving out” a certain capitated benefit back into the fee-for-service program), but for the most part the capitated setting creates results grounded in normal business transactions that are mutually acceptable to both parties, rather than political outcomes.

Accountability. In reviewing in detail the access requirements in the HealthChoices program with those under ACCESS Plus, a clear distinction emerges. The HealthChoices requirements are detailed, explicit, and numerous. The ACCESS Plus requirements are far fewer in number and tend to be much more vague. These contract differences are indicative of the heightened levels of accountability in the HealthChoices model versus what can realistically be expected to occur in the managed fee-for-service environment.

* * * * *

Nationally, enhanced Primary Care Case Management programs such as ACCESS Plus appear to be the “new thing” gaining favor among many policymakers. HealthChoices has provided superior outcomes so consistently and for so long that we are concerned that this program now exists a bit “under the radar,” i.e., it is now such an integral part of the fabric of Medical Assistance in Pennsylvania that it may be under-appreciated by the Commonwealth’s policymakers. On all fronts, HealthChoices is as effective a program as we have seen anywhere across the nation in the Medicaid arena. HealthChoices is a valuable asset to the Commonwealth of Pennsylvania.

I. INTRODUCTION

The Lewin Group was commissioned by the Pennsylvania Coalition of Medical Assistance Managed Care Organizations (the Coalition) to conduct a comparative evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service (FFS) Program, focusing on four areas that contribute to a health care program's overall value: its cost-effectiveness, its impact on access, the quality of services provided, and the program's focus on and approaches to serving individuals with special needs. The Coalition's objective was to provide an independent assessment of the value of the HealthChoices Physical Health Program to help inform the continuing debate about the future direction of the state's Medical Assistance program.

To conduct this evaluation, Lewin met with each of the seven managed care organizations participating in HealthChoices to fully understand their programs; interviewed advocates to gain their perspective on the HealthChoices Program; and spoke with staff at Pennsylvania's Department of Public Welfare to understand the current Fee-for-Service Program and plans under ACCESS Plus. Lewin also reviewed and assessed available relevant data from both the Fee-for-Service and HealthChoices programs, as well as from other state Medicaid programs.

We should note that comparisons of HealthChoices to both the traditional Fee-for-Service Program in Pennsylvania *and* the recently implemented ACCESS Plus are relevant to this assessment and are addressed in our report. Since ACCESS Plus has no track record as yet, much of our analysis of this program's impact on cost, access, and quality, and its special needs focus, involved a review of the program's contractual requirements. In addition, we reviewed available information and outcomes associated with similar programs (most also in their embryonic stages) that have been implemented in other states. Finally, we considered the cost containment techniques and other attributes of enhanced Primary Care Case Management models and projected the potential performance of the model based on these attributes.

The remainder of this report is organized as follows:

- **Chapter II, Cost-Effectiveness Assessment**, assesses the financial impacts of the HealthChoices program, Pennsylvania's capitated Medicaid managed care initiative.
- **Chapter III, Access Assessment**, reviews the level of access – along its various dimensions – that exists within the HealthChoices Program vs. the FFS Program and delineates the access enhancement initiatives taken or planned in the various settings.
- **Chapter IV, Quality Assessment**, focuses on quality measurement and monitoring, as well as quality initiatives and accomplishments, within the HealthChoices Program.
- **Chapter V, Special Needs Assessment**, discusses the key program components that are necessary to effectively serve special needs populations, and the degree to which each of these components exists in the Pennsylvania Medical Assistance program's various settings (HealthChoices, FFS and ACCESS Plus).
- **Chapter VI, Conclusion**, offers a brief synthesis of the findings of the report.

II. COST-EFFECTIVENESS ASSESSMENT

This chapter assesses the financial impacts of the HealthChoices program, Pennsylvania's capitated Medicaid managed care initiative. The components of the assessment include:

- A comparison of the capabilities of the capitated model vis-à-vis ACCESS Plus or other fee-for-service based managed care approaches.
- An assessment of the financial statements of the HealthChoices MCOs spanning the past several years, as compared with the financial performance of Medicaid MCOs in several other states.
- A comparison of overall Medicaid expenditures per capita between Pennsylvania and other states, including an assessment of the relationship between per capita costs and the degree to which states have relied upon capitated models.
- An analysis of the rates of annual cost inflation that have occurred under the HealthChoices program.
- An assessment of the degree to which the HealthChoices MCOs have raised or lowered provider payment rates in comparison to fee-for-service Medicaid.
- A delineation of some of the innovative approaches the HealthChoices MCOs have taken to achieve medical cost savings.

A. Comparison of HealthChoices Capabilities To Managed Fee-For-Service Models Such As ACCESS Plus

Exhibit A presents a pictorial comparison of FFS, ACCESS Plus, and HealthChoices across a range of cost containment attributes. As might be expected, the capitated model fosters strong use of all of the cost containment techniques. ACCESS Plus provides a mixture, fostering strong use of some approaches and more limited use of some other approaches; some features simply are not part of this model. The traditional Medicaid FFS coverage model offers minimal cost containment capabilities beyond imposing very low payment rates on the provider community.

The introduction of ACCESS Plus, the FFS-based managed care program for populations not served by HealthChoices, is likely to further strengthen the cost-effectiveness of the state's Medicaid program. However, it would not be realistic to expect this new and untested program to achieve the level of savings and cost-effectiveness that the HealthChoices model has demonstrated. Many cost containment techniques and features that are possible in the full-risk, capitated setting (e.g., a wide variety of "spend to save" initiatives, contractual relationships with providers, and the degree of local outreach services rendered) simply cannot be matched in a FFS-based Medicaid managed care program.

At the same time, initial savings could occur in that ACCESS Plus is launched against a completely unmanaged cost baseline. In contrast, much of the initial savings under the HealthChoices program have already been achieved and continue to provide the Commonwealth savings in the form of lower baseline program costs. Incremental savings under HealthChoices, while certainly possible, are much harder to achieve in this mature

program. Thus, policymakers will need to work carefully to fairly compare financial savings under the two programs, both in accurately measuring the savings each model is creating versus a similar baseline, and in not saddling those implementing ACCESS Plus with the expectation that it achieve cost savings similar to HealthChoices.

Exhibit A
Summary Comparison of Cost Containment
Features of Various Medicaid Models

Rating Key:			
● Model strongly provides this attribute			
◐ Model partially provides this attribute			
○ Model does not have this attribute			
Cost Containment Techniques	FFS	ACCESS Plus	HealthChoices
General Attributes			
Controls and Channels Patient Volume	○	○	●
Avoids Unnecessary Services	○	◐	●
Creates And Uses Network of Providers	○	◐	●
Directly Pays Providers For Health Care Services	●	○	●
Requires Lower-Cost Services Where Available	○	◐	●
Vendor At Risk for Medical Costs	○	◐	●
Achieves Favorable Unit Prices For Medical Services	●	●	●
Specific Attributes			
Primary Care Physician Required	○	●	●
Prior Authorization for Costly Services	○	◐	●
Referrals Required for Outpatient Specialty Care	○	◐	●
Disease Management	○	●	●
Case Management	○	◐	●
Enrollee & Provider Outreach and Education	○	◐	●
Management Of Prescription Drug Mix & Usage	○	○	●
Can Pay for Uncovered Services on Exception Basis	○	○	●
Provider Profiling/Reporting, Accountability for Quality and Cost-Effectiveness	○	◐	●

B. Analysis of Financial Statements

Lewin obtained financial statements from nearly all of the HealthChoices MCOs and has also obtained financial statements from a wide variety of Medicaid MCOs in other states. Altogether, 179 annual Medicaid MCO financial statements were included in the analysis. A summary of the aggregated financial performance of capitated health plans in various states is presented in Table II-1.

In Pennsylvania, the aggregate medical loss ratio of the Medicaid MCOs (medical costs divided by premium revenue¹) has been extremely consistent throughout the past decade – ranging from a low of 87.9 percent to a high of 89.6 percent. With medical costs consuming between 88 to 90 percent of revenue, the Medicaid MCOs have had approximately 10 to 12 percent of premium with which to cover administrative costs and to achieve an operating surplus. In contrast to Pennsylvania, medical costs in nearly all the comparison states constitute a lower percentage of revenue by several percentage points (and in some cases by more than a dozen percentage points). In these other programs, states are essentially paying far more to their MCOs (simply to pay for the health plans’ administrative and marketing expenses and/or MCO profit margins) than is occurring in Pennsylvania.

The consistency of the rate-setting and health plans’ financial performance in Pennsylvania is further demonstrated in II-2. While in some states the health plans’ medical loss ratio has *averaged* less than 80 percent, this result has occurred in only ten percent of the plan-years assessed under HealthChoices. Pennsylvania’s collective average has remained in the 88 to 90 percent corridor throughout the past nine years.

The rate-setting efforts of DPW appear to be exemplary in the aggregate, never resulting in either a large health plan surplus nor imposing a large deficit.² However, there is variation in profitability at the plan level, as shown in Table II-2. Some HealthChoices MCOs have experienced deficits in consecutive years and have expressed concern that the risk adjustment model “lags behind” in matching up payments in situations where plans disproportionately serve less healthy enrollees.

1 In most instances in this table, the percentages are all based on total revenue, which includes both premium income and investment income. In a few instances, the figures are based only on premium income. As investment income typically represents less than one percent of total revenue, this does not meaningfully impact the results presented. Health plan taxes have been removed from both revenue and costs where such arrangements are in use, and the operating gain/loss is prior to any taxes paid.

2 Credit for these results also goes to William Mercer, Inc., the actuarial consulting firm that has assisted DPW in the capitation rate-setting process throughout the assessed timeframe.

**Table II-1
Aggregate Financial Results Of Medicaid MCOs In Several States By Year**

State	Year	# Of Health Plans	Medical Loss Ratio	Admin Cost Ratio	Operating Gain (Loss)
Pennsylvania	1996	2	88.6%	13.7%	-2.3%
Pennsylvania	1997	3	89.6%	13.1%	-2.7%
Pennsylvania	1998	3	88.7%	11.7%	-0.3%
Pennsylvania	1999	4	87.9%	8.9%	3.1%
Pennsylvania	2000	4	88.7%	8.8%	2.5%
Pennsylvania	2001	5	87.9%	9.8%	2.2%
Pennsylvania	2002	6	88.3%	9.1%	2.6%
Pennsylvania	2003	6	88.5%	8.4%	3.1%
Pennsylvania	2004	6	88.4%	8.6%	3.0%
Texas	2001	10	84.8%	14.2%	1.0%
Texas	2002	12	82.6%	14.0%	3.3%
Texas	2003	8	82.6%	14.0%	3.3%
New York	2002	18	73.7%	19.2%	7.1%
New York	2003	18	76.7%	16.2%	7.1%
Washington State	1999	6	88.5%	11.0%	0.5%
Washington State	2000	6	86.7%	12.0%	1.3%
Washington State	2001	6	85.3%	13.5%	1.2%
Washington State	2002	6	85.3%	13.3%	1.4%
Arizona	2003	8	90.9%	7.8%	1.3%
Arizona	2003	10	92.0%	7.6%	0.4%
West Virginia	2000	2	88.2%	9.8%	2.0%
West Virginia	2001	2	87.2%	9.9%	2.9%
West Virginia	2002	2	89.5%	8.4%	2.1%
West Virginia	2003	2	88.1%	8.9%	3.0%
Illinois	2002	2	65.8%	26.2%	8.0%
Illinois	2003	4	74.0%	21.7%	4.4%

Note: # of Health Plans column reflects the MCOs for which Lewin received financial statements

**Table II-2
Assessment of 39 HealthChoices Financial Statements, 1996-2004:
Medical Loss Ratio Distribution**

Medical Loss Ratio Range	# Of HealthChoices Financial Statements In Range	Percentage Of Statements In Range
< 80%	3	8%
80 - 84.9%	7	18%
85 - 89.9%	16	41%
90 - 94.9%	11	28%
95+ %	2	5%

The Pennsylvania MCOs have lowered their administrative cost ratios significantly in recent years, from 13.7 percent of revenue in 1996 to below 9 percent of revenue in 2003-2004. This effort is directly responsible for reversing the MCOs' aggregate losses that occurred during the 1996-1998 period and enabling the MCOs to collectively achieve modest positive operating margins during each of the past six years. Administrative spending is assessed in further detail in the ensuing section.

C. Administrative Spending Assessment

The HealthChoices MCOs are collectively spending approximately \$300 million annually on administrative services. There often seems to be a public perception that the MCOs' administrative costs represent dollars that are taken away from the health care system, that

these are dollars that simply do not need to be spent. The balanced reality is that there are administrative components to everything that takes place in health care, and that an organization's administrative spending levels can fall anywhere on the continuum of efficiency and excess.

In the Medicaid MCO setting, the purpose of the administrative functions is to create an integrated system of care delivery, access, patient education and cost-effectiveness. It is not constructive to suggest that the administrative costs associated with these efforts are inherently unnecessary or wasteful. To the contrary, our key findings after analyzing the HealthChoices MCOs' administrative functions and cost levels are that the spending levels are highly efficient and that the functions being performed are exceptionally effective and valuable to Pennsylvania's Medicaid program. Also, some of the administrative functions the MCOs perform (e.g., claims processing and payment) would need to occur in the FFS setting if HealthChoices did not exist.

Of all the states assessed in the review of financial statements summarized earlier in Table II-1, only Arizona and West Virginia have had comparable administrative cost experience. Arizona's 2003 administrative expenses comprised 7.6 percent of revenue compared to the 2003 and 2004 HealthChoices averages of 8.4 and 8.6 percent, respectively. Administrative costs in West Virginia have also been held below 10 percent of revenue. The other comparison states have experienced administrative cost percentages of 11 to 26 percent.

One factor that has clearly helped the Pennsylvania and Arizona health plans in achieving efficient administrative cost ratios is that these states have mandatory enrollment for both the Temporary Assistance for Needy Families (TANF) and disabled populations. Mandatory enrollment models enable health plans to focus on "serving" rather than "selling." Also, the disabled population has less turnover than the TANF population, imposing relatively less enrollment/disenrollment processing and new member orientation per premium dollar. In addition, the high medical costs of the disabled population drive down the administrative cost ratio – per capita administrative costs for the disabled are higher than for TANF due to the extensive and tailored case management and care management efforts that are needed, but disabled administrative costs nonetheless comprise a relatively small portion of the premium dollar due to the vastly larger PMPM medical costs the disabled population experiences.

The level of services the HealthChoices MCOs are providing within their administrative budgets is compellingly positive, particularly in light of the relatively low share of premium dollars being allocated to administration. As described in the Access Assessment, the MCOs are providing an exceptional array of services to promote access to care. The Pennsylvania MCOs particularly stand out in the depth of their outreach and health education initiatives. The personal commitment of the health plans' staff (along with organizational backing) to serve the population effectively and the inter-plan competition to provide "the best service" have resulted in an exceptional array of services and initiatives being brought to bear on the Medicaid population's access and health awareness challenges. These initiatives are described in detail in Lewin's Access and Quality reports. Two examples of these initiatives are presented below:

- During 2003, one MCO placed 200,000 outbound phone calls to enrollees, 80,000 of which were related to disease management activities and 120,000 of which were outreach calls. This MCO also sent out 235,000 reminder mailings during 2003 to encourage access to preventive care.
- To promote dental access, MCOs have: 1) sent letters to every enrollee family with no record of having up-to-date preventive dental care; 2) directly provided dental cleanings and sealings in several schools; 3) systematically contacted every dentist in the service area to recruit dentists for the network; and 4) conducted “secret shopper” calls to network dentists (posing as an enrollee seeking an appointment) to assess whether practices are in fact available to the health plan’s members.

Another issue in the administrative cost arena is that medical cost management and cost containment clearly impose administrative costs – massive savings are not occurring simply through the provider contracting process (particularly in the HealthChoices setting, where very little price savings are negotiated and where the MCOs are in fact most often starting from a basis of increasing provider payments versus FFS Medicaid). It is necessary to “spend in order to save,” and the MCOs have invested heavily in utilization management staff and systems focused on provider behavior (e.g., prior authorization programs, concurrent and retrospective analyses, etc), in addition to a vast array of patient education and care coordination initiatives that are focused directly on the enrollees.

The health plans also seem to be providing all the requisite administrative functions effectively, including prompt and accurate handling and payment of claims, member services, provider contracting and relations, enrollment/ disenrollment processing, reporting to DPW, etc. These obviously are not small undertakings at the enrollment scale the plans experience, but the HealthChoices MCOs all have the significant advantage of many years of Pennsylvania-specific Medicaid experience to draw from and build upon.

D. Overall Per Capita Cost Comparison, Pennsylvania Versus Neighboring States

Working with Medicaid Statistical Information System (MSIS) data files available on the Centers for Medicare and Medicaid (CMS) website, Medicaid spending per enrollee in 2002 was tabulated for three eligibility groupings in Pennsylvania and the six states contiguous to Pennsylvania. The eligibility groupings assessed are blind/disabled (non-aged), children, and adults (non-disabled & non-aged). The results, summarized in Table II-3, indicate that Pennsylvania’s Medicaid per capita costs are fairly low within the region, particularly in the blind/disabled category. Medicaid per capita costs are influenced by a myriad of factors, and the figures in Table II-3 should not be construed as representing the savings that HealthChoices has created. We would be highly suspicious of any suggestion that HealthChoices is yielding savings of 20+ percentage points for any population group. At the same time, the general results – particularly high savings for the disabled and adult populations (who generate the highest costs and present the greatest care management opportunities) and no real savings for children (where per capita costs are much lower and where the model’s focus is on fostering access to needed care) – seem consistent with what one would expect to find in a well-managed setting. Overall Medicaid per capita cost levels in Pennsylvania are fairly low within their

geographic peer group, and we would view the state’s reliance on the capitated HealthChoices model as being partially responsible for this result.

**Table II-3
Comparison Of Medicaid Per Capita Costs Between
Pennsylvania and Neighboring States**

Medicaid Cost Per Beneficiary, 2002			
State	Blind/		
	Disabled	Children	Adults
DE	\$13,946	\$1,438	\$2,602
MD	\$13,527	\$1,642	\$2,644
NJ	\$15,204	\$1,215	\$2,223
NY	\$22,019	\$1,676	\$3,214
OH	\$14,690	\$1,240	\$2,238
PA	\$9,102	\$1,531	\$2,212
WV	\$7,949	\$1,208	\$1,939
Weighted Avg.	\$15,948	\$1,492	\$2,772
PA as % of Area Average	57%	103%	80%

Table II-4 presents per capita costs in the nine largest Medicaid programs in the eastern United States across the same eligibility groupings (also showing aged eligibles) and depicting the degree to which Medicaid expenditures in each category were paid via capitation or FFS. The nine states are Florida, Illinois, Maryland, Massachusetts, Michigan, New Jersey, New York, Ohio and Pennsylvania. The data source used was the MSIS reports each state files with CMS annually. Reports from 1999, 2000, and 2001 were downloaded from the CMS website and assessed. Cost per eligible statistics were developed by dividing the overall expenditures by eligibility category (Table 3 in the CMS MSIS reports) by the number of eligibles (Table 1 of the CMS MSIS reports). Eligibility categories were subtotaled in the following four groups: aged beneficiaries (“aged”), disabled beneficiaries below age 65 (“disabled”), non-disabled adults below age 65 (“adults”), and non-disabled children (“children”). Prior to calculating costs per eligible, nursing home expenditures were removed to avoid the distortions – particularly in the “aged” category – that can be caused by states’ varying long-term care eligibility policies.³

³ No other adjustments were made to equalize benefits packages or eligibility rules. While there likely are some benefits package distinctions that are having some affect on the average cost figures, such differences are extremely difficult to quantify and not likely to explain much of the cost variation between these states. In general, states in the Mid-Atlantic area tend to have fairly generous Medicaid benefits packages.

**Table II-4
Correlation Between Costs Per Eligible and Use of Capitated Model**

		2001 Costs Per Eligible
Adult Subtotals	Average, States >50% \$\$ Capitated	\$1,883
	Average, States 15-49% \$\$ Capitated	\$2,704
	Average, States <15% \$\$ Capitated	\$2,256
Aged Subtotals	Average, States >50% \$\$ Capitated	na
	Average, States 15-49% \$\$ Capitated	\$3,514
	Average, States <15% \$\$ Capitated	\$4,372
Blind/Disabled Subtotals	Average, States >50% \$\$ Capitated	\$6,466
	Average, States 15-49% \$\$ Capitated	\$9,428
	Average, States <15% \$\$ Capitated	\$9,727
Child Subtotals	Average, States >50% \$\$ Capitated	\$1,165
	Average, States 15-49% \$\$ Capitated	\$1,417
	Average, States <15% \$\$ Capitated	\$1,148

Source: Tabulations using MSIS data. Averages based on nine large eastern US states: FL, IL, MD, MA, MI, NJ, NY, OH, and PA.

The findings suggest a correlation between greater use of capitation and lower costs per eligible, and therefore support the previous finding that HealthChoices is likely contributing to Pennsylvania’s relatively low per capita costs. Calendar year 2001 per capita costs tended to be lowest in states where 50 percent or more of Medicaid spending for a given population group was capitated. This trend was most pronounced for the disabled population, which is consistent with the theory that the MCO model has a larger opportunity to contain costs for disabled persons (where eligibility is stable, inpatient and pharmacy usage is high, and where chronic conditions exist). The two states that rely on capitation most heavily (Pennsylvania and Michigan) for their Medicaid disabled populations are also the two states that experienced the lowest per capita Medicaid costs.

There are some limitations to using the MSIS data files. Because states vary in the level of optional Medicaid benefits, Medicaid provider payment rates, and eligibility categories – as well as in underlying medical cost dynamics – these findings cannot be considered definitive regarding the impact of managed care. However, this assessment does suggest that capitated programs are having a sizable, cost-reducing impact, particularly for the disabled population. Pennsylvania experienced the second-lowest per capita costs per disabled eligible among the nine states assessed.

E. HealthChoices Impacts On the Rate of Cost Escalation

The rate of cost increase was assessed by tabulating DPW’s Data Book figures for the FFS population, and by tabulating costs for each health plan based on information submitted to DPW (referred to in the DPW report package as “Report 5”).

In Table II-5, rates of annual cost escalation were tabulated at the rate cell level for the “bookend” years for those MCOs that provided “Report 5” data across at least a three year timeframe. Cost escalation rates were then averaged between rate cells and regions based on

each rate cohort's share of overall claims costs. This methodology controls for the distribution of covered months across rate cells.

The Health Choices annual cost escalation rates were tabulated by looking at both average premium increases (which represent DPW's rate of cost increases under HealthChoices) and the health plan's own rate of medical cost increases. Looked at either way, the cost escalation has been modest under HealthChoices. As shown in Table II-5, the HealthChoices MCOs have collectively been able to hold overall annual medical cost escalation below eight percent throughout the past several years, in the face of considerable inflationary pressures (particularly in the pharmacy arena where annual cost increases averaging above 15 percent have been common throughout the nation).

**Table II-5
Comparisons Of Annual Rate of Cost Escalation**

Medicaid Population Group	Years Assessed	DPW Annual PMPM Cost Escalation*	MCO Annual PMPM Medical Cost Escalation
Pennsylvania Fee For Service Medicaid**	1999 – 2002	10.4%	n/a
MCO Average***	2001 – 2004	7.4%	7.9%

* DPW's cost escalation reflects health plans' premium increases.

** 2002 was the most recent available year for FFS data.

*** Averages are first calculated for each health plan by assessing PMPM cost escalation in each rate cell across a fixed set of enrollment numbers (to ensure that the cost trend is not being driven by changes in enrollment mix). The average rates of increase for each health plan are then averaged together weighted by each plan's 2003 enrollment level.

Table II-6 presents the HealthChoices MCOs' rates of cost escalation for pharmacy, which have been held below ten percent per year. The HealthChoices MCOs have focused intensively on pharmacy costs throughout the past several years and have clearly held costs well below national trends and Pennsylvania's FFS trendline. According to Drug Trend Report published by Express Scripts, nationwide unmanaged PMPM prescription drug costs have increased by 15.5% to 18.5% each year from 1999 through 2004. This trendline impact provides additional evidence of Medicaid health plans' ability to manage the Medicaid prescription drug benefit effectively despite the MCOs not having access to the Federal rebates. One earlier Lewin study has identified that Medicaid MCOs are achieving 15% lower PMPM pharmacy costs than Medicaid FFS *after* factoring in all rebates, and a second analysis focused on Arizona's program further indicated that pharmacy costs would be lowest if retained as a capitated benefit rather than a "carve-out."⁴

⁴ "Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Setting," (Beronja et al, January 2003), and "Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System," (Beronja et al, November 2003). Both studies can be downloaded in their entirety at no cost at the following website: www.lewin.com

**Table II-6
Pharmacy Cost Escalation Rates Under HealthChoices**

Medicaid Population Group	Years Assessed	Annual PMPM Rx Cost Escalation
Pennsylvania Fee For Service Medicaid	1999 – 2002**	14.4%
HealthChoices MCO Average*	2001 – 2004**	9.1%

* See notes to Table II-5 regarding averaging methodology used.

** 2002 was the most recent available year for FFS data. The difference in the timeframes could create a slight comparison distortion between the MCO and FFS averages for pharmacy. Nationally, the rate of Rx cost escalation appears to have decreased by approximately two percentage points in 2003 and 2004 versus the previous years. If the time periods were matched up, the difference in annual cost escalation between the two settings could be closer to 3-4 percentage points rather than the five point differential shown.

The reasonable rate of cost escalation experienced under HealthChoices is an extremely important program accomplishment, particularly in light of the fiscal constraints DPW has operated under and the large proportion of the State’s Medicaid costs that occur in the HealthChoices zones. We estimate that DPW’s capitation payments to the HealthChoices MCOs totaled approximately \$3.5 billion in 2004. Thus, every percentage point of HealthChoices cost savings is worth \$35 million to the Medicaid program. Our analyses clearly suggest that the savings created through HealthChoices are significant and compounding favorably over time.

While savings amounts are difficult to quantify given the absence of FFS in the HealthChoices zones, we are convinced that enormous savings have occurred under HealthChoices. Mandatory enrollment programs always seek to build in at least a 5 percent capitation rate savings to the Medicaid program at the outset, and the trend line within the capitated setting has been lower than FFS claims cost trends. If we assume that savings in the Southeast Zone have now reached 15 percent given the vast number of years capitation has been in effect in that area, and averaged 10 percent in the other two zones, the total five year savings from CY2000 to CY2004 would be approximately \$2.7 billion. In the current fiscal climate, one could argue that the state is going to address its fiscal imperatives one way or another and that the term “savings” is somewhat misleading. At a minimum, however, the HealthChoices program’s cost management success staves off the need to impose damaging cuts to the Medicaid program (e.g., benefits, eligibility, and/or provider rate reductions), an approach that has occurred in one state after another during the past five years.

Looking forward, if a continued cost escalation rate differential of two percentage points occurs⁵ across the upcoming five years for the entire HealthChoices population, the total additional expenditure difference during that five-year period will exceed \$1.3 billion. Even if only a one percentage point differential occurs each year, the five-year spending differential will be approximately \$700 million versus providing the same benefits to the same persons in the FFS setting. Thus, total savings during the upcoming 5 year period are likely to be \$3.5 - \$4.0 billion in relation to providing the same benefits to the same persons at the same fee schedule.

F. Price Management Versus Care Management

While it is not possible to measure this precisely within the scope of our study, it seems evident that the HealthChoices MCOs are paying more for the care that occurs than the Medicaid FFS system would have paid for the same services. Thus, in the aggregate, none of the HealthChoices program savings are created through price reductions; and all of the savings are attributable to *actual management of care*: utilization management, care coordination, patient education, etc. Each MCO was questioned about their provider payment methodology and amounts for various key services, and provided estimates of the amounts that DPW would have paid under FFS Medicaid had the same volume and mix of services occurred in both settings. Responses to these inquiries are summarized below.

Hospital payments. For inpatient care, the most common payment arrangement is for the MCOs to pay per case rates at or near the rates established by DPW for FFS Medicaid patients. Health plans indicated that their case payment rates averaged five to ten percent above Medicaid's FFS case rates. In some instances, the MCOs' negotiated inpatient case rates are in the vicinity of ten percent below the Medicaid rates, although this is typically not a "discount for volume" transaction. Rather, the negotiated reduction acknowledges that the average length of stay (ALOS) in the capitated setting is likely to be well below ALOS in the unmanaged setting upon which FFS case rates are established.⁶ In a few instances, MCOs are paying case rates that are far above the Medicaid case rates, simply due to the fact that the hospitals have significant market leverage and the MCO is willing to pay what is needed to include the hospital in its network.

Per diem arrangements are also used by some plans for some hospitals. Such arrangements have the advantages of matching payment more precisely to the volume of services rendered during each admission, and of ensuring that cost savings occur when length of stay (LOS) is reduced (although some also argue that per diems encourage and reward longer lengths of stay). Due to the reductions in LOS, the MCOs' per diem rates tend to result in a reduction in per case payments versus FFS Medicaid. However, the negotiated per diem rates tend to average around 15 percent *above* the amounts that would be derived by simply dividing the case rate by average length of stay. Thus, the inpatient savings that are occurring are achieved by

⁵ A two percent difference is smaller than what was identified in Table II-5, but likely a 1-2 percent differential is more realistic to use going forward in that further incremental savings are increasingly difficult to achieve in such a mature program.

⁶ It is perhaps interesting to note that some MCOs have pointedly "gotten out of the business" of managing length of stay, which has often been a time-consuming and adversarial process. Per case rates leave it in the hospitals' interest to manage length of stay, and enable MCO staff to focus more efforts on other aspects of care management to prevent hospitalizations from occurring.

preventing hospitalizations and by shortening ALOS, as opposed to negotiating rates downward versus FFS Medicaid.

Health plan payments for outpatient hospital services were based on Medicaid's fee schedule and tend to be approximately ten percent higher than FFS Medicaid payment rates.

Physician payments. Primary care physicians are often paid on a capitation basis. Most PCPs seem to favor this approach due to the cash flow advantages and the elimination of the need to bill and collect for a large volume of fairly low-cost events. While capitation makes it more difficult to contrast what the net payments to PCPs are versus what would have been paid under FFS Medicaid, some MCOs have analyzed this and found that their PCP capitation payments are equating to roughly 105 to 110 percent of Medicaid FFS. At least one MCO pays PCPs on a FFS basis and the rates are ten percent above Medicaid's fee schedule.

The vast majority of specialist physicians care in the HealthChoices program occurs through FFS payments. On average, the health plans tend to pay specialists 10 to 20 percent above the Medicaid fee schedule. There are no known instances where the HealthChoices MCOs are paying specialists less than the Medicaid rate. The higher payments and prompt payment of claims are important features in helping the MCOs achieve a broad specialty network. Between the underlying low Medicaid payment structure and the inherent dislike many specialists have for the MCO coverage model, attracting specialists to the network who do not otherwise accept Medicaid is often a challenging (and expensive) proposition. In some instances, the MCOs have made large-scale investments in paying much higher fees to address problem areas (a shortage of network participants in a certain specialty, such as orthopedic surgeons) in their specialty network.

Other provider payments. Payments to other providers were not assessed in any systematic detail. In the pharmacy arena, MCOs cannot access the large federal rebates that DPW receives, but the MCOs have negotiated lower dispensing fees at pharmacies than are paid under FFS Medicaid. In other areas, one MCO indicated that its skilled nursing facility and home health payments are slightly (less than five percent) above Medicaid FFS rates.

Price savings opportunities. MCOs are not at all adverse to seeking out price saving opportunities, but they are significantly constrained by the already low Medicaid payment levels and the need to attract and maintain a provider network that provides strong access to care and attracts enrollees. As capitation rates paid under HealthChoices largely reflect DPW's underlying payment rates for Medicaid, it is understandable that the MCOs' provider contracting results in payments that are, on the whole, closely aligned with Medicaid's structure. At the same time, Medicaid's payment schedule results from both analytical and political processes. Also, new procedures are sometimes reimbursed at a very high rate by Medicaid FFS until a payment policy is developed. Thus, MCOs in some instances have found it beneficial to completely depart from the Medicaid payment approach and negotiate a separate arrangement. A few examples of actions that have led to significant price savings in specific areas are provided below:

- Through competitive and selective contracting, a plan's durable medical equipment (DME) network was reduced from about 70 providers to five. This achieved a substantial price savings and in no way jeopardized access.

- One health plan identified a list of 50 CPT codes where DPW was paying above the Medicare allowed charge (including one code where the FFS rate was more than ten times the Medicare rate). Since the MCO's payments are based on the underlying Medicaid fee schedule, the MCO has worked with DPW to identify procedures where Medicaid seems to be overpaying and to foster revision of these high payments.
- Medicaid FFS initially paid amounts above commercial insurance rates for Positron Emission Tomography (PET) scans. A health plan negotiated amounts that were \$300 below Medicaid FFS rates. DPW subsequently developed its own set of lower PET scan rates.
- Titanium rib implants have costs associated with the initial insertion as well as replacements and expansion after the ribs have been extended to their full length. Usual pricing for this procedure was approximately \$10,000 for the initial implant, \$7,000 for replacement and \$45,000 for expansion. A MCO was able to negotiate a rate of approximately \$1,000 for each surgical procedure.
- FFS Medicaid pays a bundled rate to obstetricians that covers the delivery and some postpartum care. A health plan has unbundled this rate such that it does not pay twice for the postpartum services in situations where a different physician provides postpartum care than the physician who performed the delivery.
- Medicaid's payments for oxygen were above Medicare rates for some time; the health plans negotiated lower rates for oxygen and DPW has also subsequently reduced the Medicaid FFS payment levels.
- One MCO renegotiated price arrangements with 973 specialists and two hospital systems, creating an annual savings of approximately \$3 million.
- Through its per diem contracts with hospitals, one MCO has established "alternate level of care" reimbursement rates that are 29 percent below the average per diem. The alternate level of care per diems are used when the patient no longer requires an acute level of care, but cannot yet be discharged.

G. Innovations In Medical Cost Management

The HealthChoices MCOs provided several innovative examples of situations where they invested money in a targeted manner that led to cost savings (and in many instances strengthened access to care as well). Some of these examples are briefly described below.

Extended Primary Care Hours. One MCO paid the up-front costs needed to enable an FQHC to extend its hours into the evening. This investment substantially improved access to care in the FQHC's neighborhood and also proved cost effective for the health plan by lowering the area population's need/desire to use the emergency room.

Emergency Room (ER) Initiatives. Avoiding emergency-room care, both by averting health crises in the first place and by promoting the use of the 24/7 PCP phone access and member services line in lieu of using the ER, is understandably an important component of all the health plans' medical management efforts. Several of the MCOs have recently targeted interventions toward patients and their families who have a high volume of ER usage, as well as

implementing initiatives focused on providers. An innovative approach taken by one MCO involved assessing the degree to which frequent ER users disproportionately were aligned with certain PCPs. The plan called these physicians' offices after hours to assess whether the voice-mail message was overly discouraging of obtaining the physician's direct input and too readily referring callers to the ER (which in some instances was the case and which prompted efforts to work with these physicians to change the message content). Another MCO calls members within 24 hours of an ER visit to try and educate them about the appropriate use of the ER and also follows up with the members' PCPs.

Pharmacy Initiatives. A wide range of pharmacy cost management initiatives have been implemented, fueled at least to some degree by the rapid rate of prescription drug cost escalation all payers have experienced throughout the past five years. Some examples include extensive physician and patient profiling analyses with follow-up action steps, a "polypharmacy" program targeting persons using a particularly large volume of drug therapies, a drug utilization review (DUR) initiative for Neurontin, which produced an annual savings of more than \$3 million, working intensively with psychiatrists to foster greater use of generic Clozaril (\$750,000 annual savings), and implementing focused initiatives on injectable drugs.

Disease Management. The HealthChoices MCOs have implemented a comprehensive array of disease management programs, including a wide range of programs for high-risk pregnancies, asthma, diabetes, hemophilia, and congestive heart failure (CHF). A plan's targeted efforts to coordinate care for high risk pregnant women lowered its proportion of NICU births from 11 percent of all births in 2002 to 7.5 percent in 2004. The MCOs also aggressively track their performance in achieving "early and often" prenatal care, measuring the degree to which prenatal care is occurring in each trimester. A health plan that focused on hemophilia case management found that 38 patients were generating \$12 million in annual claims. The case management program was both popular and cost-effective; a year after its implementation the health plan found that it now had 50 high-need patients (as patients and providers liked the program and word of mouth spread) but that the total claims costs across this larger group were only \$8 million. In other words, per capita treatment costs were reduced by nearly 50 percent. Another MCO cited annual savings of more than \$2 million due to its implementation of additional disease management initiatives.

Claims Coding Initiatives. Most of the MCOs apply National Correct Coding Initiative (CCI) edits, as well as other acceptable edits, as part of their claims review and payment processes. The use of CCI edits, which consist of automated edits to evaluate claims submissions when the provider bills more than one service for the same beneficiary and same date of service, is mandatory in the Medicare program, but is not mandatory for state Medicaid agencies. An October 2004 report of the U.S. Department of Health and Human Services Office of the Inspector General (OIG)⁷ found that only seven states use some or all of the CCI edits in their Medicaid programs; Pennsylvania does not. In its review of 2001 Medicaid claims data, the OIG further found that 39 states paid \$54 million for services that would have been denied if the CCI

⁷ Department of Health and Human Services, Office of Inspector General, *Applying the National Correct Coding Initiative to Medicaid Services*. October 2004, OEI-03-02-00790.

edits had been used. Through the use of CCI and other edits, the HealthChoices MCOs have achieved savings that have not yet been pursued in the FFS program.

Coordination of Benefits (COB). Some concerns have been expressed by DPW that the MCOs are not being sufficiently aggressive and sophisticated in identifying COB situations. While Lewin has not conducted an explicit assessment of this issue, in general the MCOs appear to be developing stronger capabilities in this area, and one in particular has been extremely proactive in cost avoidance and COB recoveries. This MCO has developed relationships with several commercial carriers and pharmacy benefits managers to exchange eligibility files and has recovered payments totaling more than \$2 million since January 2003 as a result of such efforts. Another MCO has established a dedicated third party liability (TPL) unit to better identify opportunities for cost avoidance and recovery of paid claims, as well as better manage the DPW TPL file process. Several MCOs expressed concern with the accuracy of the COB information DPW captures and provided examples of situations in which the MCO had recovered and avoided significant amounts (one claim exceeded \$100,000) but no COB information had been captured by DPW. Clearly, the health plans have always been interested in avoiding payment where appropriate in COB situations. This issue appears to be primarily one of addressing the data challenges that confront both DPW and the MCOs, given that enrollees who have other coverage often do not notify DPW or their MCO of the existence of the other coverage.

Fraud/Abuse Improvement. One MCO hired an external consultant to assist in better identifying fraud/abuse opportunities and to establish formal processes when providers or members are suspected of fraudulent or abusive behavior. The policies include stipulating the circumstances in which such cases law enforcement agencies will be apprised.

The above list serves simply to provide some examples of MCO activities across different areas. The breadth of the cost containment programs the HealthChoices MCOs have implemented is exceptional, as is the degree to which the MCOs monitor the impacts of their programs and continually seek to improve their cost containment performance. Also, it is worth noting that many of the Pennsylvania MCOs serve Medicaid populations in other states (and/or serve additional Pennsylvania populations) and thus are able to bring to the HealthChoices program cost containment programs that have been successfully implemented elsewhere.

H. Concluding Remarks

HealthChoices is a highly successful program financially, serving as a national model. Pennsylvania's per capita Medicaid costs compare favorably with the neighboring states, particularly for the disabled population where the MCO savings impacts would be expected to be greatest. DPW's rate-setting efforts and the MCOs' operational performance have both been exemplary when contrasted with capitated managed care programs in several other states. The collective medical loss ratio (medical costs as a percentage of revenue) of the HealthChoices MCOs is approaching 90 percent, with the MCOs in the aggregate holding administrative costs to approximately eight percent of revenue and achieving an operating margin of approximately three percent.

Consistently, the HealthChoices MCOs have done well at holding down rates of medical cost escalation. The HealthChoices MCOs have collectively held the rate of PMPM medical cost escalation below eight percent throughout the past several years. Importantly, the cost-

effectiveness that is occurring under HealthChoices is predominantly attributable to coordination of care and patient outreach that avoids relatively high cost services and slows the rate at which high-cost treatments need to occur. The HealthChoices program has served as a vehicle for propping up (or at least maintaining) – rather than ratcheting down or discounting – unit prices paid to safety net providers vis-à-vis Medicaid FFS rates.

DPW monitors the HealthChoices program aggressively and obtains an extensive array of financial reports to track the MCOs’ utilization and cost performance. The MCOs, in turn, go far beyond providing required materials to DPW in tracking their own performance, and continually seek out innovative ways to achieve additional cost efficiencies.

If national policymakers were to create a list of key desired financial outcomes from a Medicaid managed care initiative, the HealthChoices program has delivered on all aspects. The program has delivered massive savings, and the level of savings continues to compound upwards as the MCOs hold down the rate of cost escalation. Administrative costs are consuming a low percentage of revenues, yet the MCOs are providing a compelling array of educational, outreach and other tailored initiatives within their administrative budgets (in addition to providing all the “routine” functions such as claims processing and payment). MCOs are generally paying network-participating hospitals and physicians above the amounts they would have received from FFS Medicaid for the same services. Also, the MCOs have achieved a modest operating income (e.g., two to three percent) as is necessary to ensure a stable program with experienced MCOs that continually participate.

In recent years, one state after another has imposed various cuts in their Medicaid program. The tools most commonly used include:

- tightening eligibility requirements, which leaves thousands of previously covered persons uninsured and greatly limits their opportunity to obtain routine and preventive care;
- restricting benefits, which weakens the quantity and quality of the coverage Medicaid is providing, jeopardizing access and health status for many recipients; and/or
- cutting provider payment rates, which tends to make it even more difficult for mainstream providers to maintain their level of involvement in the Medicaid program (exacerbating the access barriers and issues that already undermine the value of Medicaid coverage).

While the HealthChoices program has clearly provided large-scale savings to the Commonwealth of Pennsylvania’s taxpayers, perhaps more importantly it has enabled Pennsylvania to stand apart from most other Medicaid programs in recent years and preserve the Medicaid program’s eligibility, benefits, and provider payment levels.

III. ACCESS ASSESSMENT

A. Introduction

The establishment of the Medicaid program in 1965 provided the financial means for low-income children and adults, as well as low-income elderly and disabled individuals, to obtain health care. However, as has become increasingly apparent over the past several decades, financial coverage does not, in and of itself, ensure true access to needed health and medical services. Lack of access to care comes at a high cost to those with medical needs as well as for the health care system because these individuals may present in the emergency department for routine care or delay care until their condition is serious enough to require hospitalization. Access to and receipt of needed care by Medicaid recipients is affected by a plethora of factors, including but not limited to the following:

- **Level of physician participation in the Medicaid program.** Low payments have been a longstanding issue in many states' Medicaid programs and have clearly affected doctors' willingness to treat Medicaid beneficiaries. Despite their generous benefits packages, state Medicaid programs across the country are often considered to be second class systems of coverage. Many attribute this at least partially to low reimbursement levels that limit the involvement of "mainstream" providers. Fee levels for front-line health professionals play a critical role in the way health care is accessed by and delivered to Medicaid beneficiaries. The lower the fees, the more difficult it is to assure beneficiaries access to a comprehensive provider network similar to what is available to Medicare beneficiaries and privately insured persons.
- **Degree to which participating physicians are accepting new patients.** Low fees also make it more difficult to access even those providers who already participate in Medicaid. These providers often find it necessary to close their practices to new Medicaid patients. Thus, mere counts of providers participating in Medicaid are often misleading, since many participating providers severely limit the number of Medicaid patients they serve.
- **Ease with which the Medicaid recipient can locate a physician who participates in Medicaid and whose panel is open to new patients.** Traditional Medicaid FFS programs often do not provide assistance to recipients in finding physicians who accept Medicaid. All too often, the approach is effectively one of "Here's your Medicaid card, have at it." A study conducted recently by the U.S. Government Accountability Office suggests that the lack of assistance given to recipients in locating physicians often stems from the poor data that FFS programs maintain regarding participating physicians.⁸

⁸ Government Accountability Office (2003), "Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care" (GAO-03-22).

State lists of physicians accepting Medicaid may include physicians who only see Medicaid enrollees in specific circumstances, such as in hospital emergency rooms and during hospital consultations, but do not accept Medicaid coverage for visits in their private offices. The lists also may include hospital-based physicians such as anesthesiologists and pathologists, whose services are critical, but do not improve access to primary care.

“Despite the potential for low FFS rates to limit the number of providers willing to participate in the program, the nine states we reviewed with traditional FFS programs did not set specific goals for the number of physicians participating in their Medicaid programs and did not actively monitor the number and location of providers. While states had lists of physicians who were enrolled as Medicaid providers and who submitted claims for services provided, in most cases these lists were not frequently or comprehensively updated and thus did not provide an accurate count of actively participating physicians. Some states’ Medicaid physician databases included physicians who had not provided services to Medicaid patients for years... In addition, although states have claims data that serve as the basis for paying providers for services rendered, only some analyzed this information to identify PCPs, specialists, or other providers who were actively treating Medicaid beneficiaries. Even when they did, states often defined “active” providers to include those who submitted a single claim during the past year.”

- GAO-03-222

- **Proximity, appointment availability, and other “ease of accessibility” factors.** Geographic location, physical structure, convenience of office hours, and appointment waiting times are generally more important indicators of access than is the size of the provider network. For instance, how far does the Medicaid recipient have to travel to the physician’s office? Is it wheelchair-accessible? Does the office offer weekend or evening hours? Medicaid-participating physicians also are more likely to carry a very high patient load, which can create further concerns regarding in-office and appointment waiting times and the amount of time practitioners are able to spend with each patient.
- **The degree to which cultural, language, and other barriers exist and the extent to which the recipient’s health care delivery system addresses them.** Medicaid recipients often face significant cultural, language, socioeconomic, and psychosocial barriers to accessing health care. Compared to the general population, they are more likely to have lower literacy levels, have a primary language other than English, have less formal

Examples of Enabling Services and Other Mechanisms That Facilitate Access and Appropriate Utilization of Services

- √ Transportation
- √ Interpretation services
- √ Identification of languages spoken in provider offices
- √ Attention to cultural appropriateness of provider network
- √ Cultural sensitivity training for providers/administrative staff
- √ Health education and outreach programs
- √ Attention to the multiple social factors that influence health status and coordination of needed services

education, belong to racial/ethnic minorities, face difficulties such as substandard housing or homelessness, and/or have belief systems that are in conflict with traditional Western medicine. Such barriers make it difficult for Medicaid beneficiaries to navigate an already complicated health care system and therefore interfere with their health care needs being fully met. The structure of the individual’s health care

delivery system, i.e., whether it includes enabling services and other mechanisms for addressing these barriers (see box above) is a key determinant of access to and appropriate utilization of services.

In the remainder of this chapter, we discuss the state of access—along its various dimensions—in the Commonwealth of Pennsylvania’s Medical Assistance program. We present data, both quantitative and qualitative, that provide insights into the level of access that exists within the HealthChoices program vs. the FFS program and delineate the access enhancement initiatives taken or planned in the various settings (HealthChoices, FFS, PCCM, EPCCM).

B. Level of Active Provider Participation in Pennsylvania’s Medical Assistance Program

As discussed in the previous section, access to services in the Medicaid program is often severely limited simply because low fees lead to many providers choosing not to participate in the program. Those who do participate often limit the number of Medicaid patients they will accept. Below we present our findings on this broad access measure within the context of Pennsylvania’s Medical Assistance (MA) program.

1. Fee-for-Service Program

For many of the reasons cited above, it is difficult to measure the level of active physician participation in FFS programs, and The Lewin Group was unable to obtain counts of actively participating physicians in Pennsylvania’s FFS program. Given MA payment levels in Pennsylvania, though, it is reasonable to conclude that Pennsylvania faces challenges at least equal to those faced by other states in obtaining physician participation in the program.

In 2001, The Lewin Group conducted a study comparing FFS payment rates paid by each state’s Medicaid program, and contrasted the states’ fees as a percentage of Medicare’s average allowed charge.⁹ Pennsylvania’s payments to physicians were found to be well below average when contrasted with all states’ fee schedules. Pennsylvania’s ranking among 51 Medicaid programs for an aggregation of physician services was 43rd in terms of unadjusted fees, 43rd when all states’ fees were adjusted by geographic cost factors, and 43rd as a percentage of the average Medicare allowed charge. On average, Pennsylvania’s MA physician fees represented 63.5% of statewide average Medicare allowed charges. Among the ten largest states, Pennsylvania ranked 8th. In the GAO study cited earlier, Pennsylvania MA fee levels fared even worse: among the 13 states reviewed, Pennsylvania’s Medical Assistance FFS payment rates as a percentage of Medicare FFS rates, at 32%, ranked the lowest.

These statistics, combined with anecdotal information of poor provider participation in certain (particularly rural) areas of the state and in certain specialties (e.g., dental, obstetrics, orthopedics), do not paint a rosy picture of access within Pennsylvania’s MA program, despite claims that the MA provider network includes 68,000 providers.¹⁰ And while the Pennsylvania Governor’s 2005-2006 budget calls for modest (2%) rate increases to some MA providers

⁹ The Lewin Group (2001), *Comparison of Physician and Dental Fees Paid by State Medicaid Programs*.

¹⁰ Commonwealth of Pennsylvania, *2005-06 Governor’s Executive Budget*, available at http://www.budget.state.pa.us/budget/lib/budget/2005-2006/presentation/2005_06BudgetSlides.pdf.

(hospitals, nursing homes and managed care organizations), it does not appear that the budget includes funding to support MA rate increases for physicians and other providers (other than the enhanced PCP reimbursement in ACCESS Plus).¹¹

However, with the implementation of the ACCESS Plus program, the state will be engaging in a number of efforts that it hopes will enhance the level of provider participation in the program in the FFS setting. For instance:

- Under the ACCESS Plus program, primary care providers (PCPs) will be paid an enhanced rate for primary care services provided to enrollees on the PCP's panel.¹² Such enhanced PCP reimbursement typically is incorporated in PCCM programs and often does have a positive impact on the active participation of primary care providers.
- In addition, the ACCESS Plus Draft Agreement states that "the Contractor may seek additional independent sources of Provider listings, such as the Department of State Board of Licensure, to identify PCPs who may be willing to participate in ACCESS Plus who are not currently participating in the MA program," presumably in an effort to increase the number of PCPs available to ACCESS Plus enrollees. However, the contractor will not be required to recruit providers other than PCPs.

The ACCESS Plus vendor must maintain a toll-free phone line for providers to address issues related to the ACCESS Plus program.

2. HealthChoices Program

In order to participate in the HealthChoices program by contracting with one or more of the HealthChoices MCOs, providers must have a PROMISE ID or MA Identification (MAID) number, i.e., have an agreement with the state to participate in the MA program. Thus, at face value it would appear that the MA MCOs are limited in their ability to increase the size of the provider network for their members. However, as discussed previously, the absolute number of providers with an MAID number is somewhat meaningless, as many certainly do not actively serve Medical Assistance recipients and/or severely limit the number of Medical Assistance recipients on their panel. Despite the obstacles to increasing provider participation, the HealthChoices program structure and MCO practices have strengthened provider networks to ensure access to care for members:

- MCO networks are required to meet explicit contractual provider network standards
- MCOs enhance networks through provider payment practices and initiatives
- MCOs regularly perform and respond to network analyses
- MCOs improve provider participation in Medical Assistance
- MCOs cultivate their relationships with providers

¹¹ Ibid.

¹² This reimbursement provision is included in the Pennsylvania Department of Public Welfare's "Supplemental Provider Agreement for the Delivery of Primary Care Case Management Services by Primary Care Providers."

Below we discuss each of these and how they foster enhanced and active participation by providers in the HealthChoices program.

a. MCO networks are required to meet explicit provider network standards

The state has delineated several requirements for provider network composition within the HealthChoices program. In developing their networks, the MCOs are contractually required to take into account the anticipated Medical Assistance enrollment, the expected utilization of services, the number of providers who are not accepting new patients, and the location of providers. Members must have a choice of at least two PCPs or pediatricians within a travel time of 30 minutes (urban) and 60 minutes (rural). Other standards surrounding choice of providers, access to specialists, travel times, and appointment standards also are outlined in the MCOs' contracts with the state; many of these are described elsewhere in this chapter. (In contrast, the unmanaged FFS system has *no* requirements relative to numbers and location of providers, and the ACCESS Plus program includes requirements relative to the PCP network only; beneficiaries will be served by specialists in the FFS program, with no special or additional requirements regarding the specialist network.)

It should be noted that Pennsylvania appears to be particularly proactive in setting access requirements for its MA MCOs and in monitoring compliance with standards. In the 2003 GAO study ("Medicaid and SCHIP: States Use Varying Approaches to Monitor

Among 14 states reviewed in the GAO study, Pennsylvania was the only state to have set forth specific Medicaid managed care network requirements in each of the following areas:

- size and structure of PCP network
- size and structure of specialist network
- geographic distribution of network
- appointment waiting times: first visit
- appointment waiting time: appointment scheduling
- appointment waiting times: in-office waiting time

Children's Access to Care"), Pennsylvania consistently ranked at or near the top of the states reviewed in terms of standard-setting and monitoring activities. Certainly, the state's efforts in designing and monitoring the program, and in holding its contractors accountable for achieving standards, have exceeded the norm.

b. MCOs enhance network through provider payment practices and initiatives

MCOs have the benefit of flexibility in setting provider payments and can decide to pay providers at or above the Medical Assistance fee schedule to encourage their participation. The HealthChoices MCOs have successfully leveraged this flexibility in negotiations with providers. All of the MCOs generally pay physicians at rates at least 5-10% above the FFS rates; rates for hard-to-recruit specialists are often 30-40% above the MA fee schedule, or even higher.

"We use a lot of reimbursement methods to fill any holes we find in our network. Our flexibility to alter the fee schedule down to a single physician, even down to a specific procedure code, is often what helps bring physicians into our network."¹³

¹³ From Lewin interview with a staff person from a HealthChoices MCO. Unless otherwise noted, all quotes in the remainder of the document are based on interviews with MCO staff.

It should be noted that MCOs also have the ability to lower payment rates, and they sometimes do (e.g., they pay lower pharmacy dispensing fees than does the FFS program). However, we have seen this occurring only where there are no access issues.

The HealthChoices MCOs also are often able to negotiate payment rates with non-participating providers to ensure that their members have access to needed care when it is not reasonably available within the network. In addition, a couple of the MCOs described instances in which they allow certain specialists to participate in the network without actually being listed in the health plan's Provider Directory. For instance, there are some specialists who express concerns about being inundated with Medical Assistance patients if they are in the Provider Directory, but are willing to accept certain members who have special needs.

"Dental is always a problem, but especially for our kids with special needs. We've been able to negotiate an arrangement with a couple of dentists who have agreed to treat kids with special needs. At their request, we do not list them in the directory. While this may not be ideal – we'd rather have these dentists accept all members – it does enable us to provide needed services to a population for whom access has historically been especially difficult."

"We allow some specialists to participate without being in the directory. Dental is one example; ophthalmology, especially pediatric ophthalmology, is another."

Many of the HealthChoices MCOs also use **incentive payments** to encourage vigorous participation by providers in their networks. For instance, a number of the MCOs enhance capitation rates for those PCPs who have extended office hours, expand their panels (i.e., keep their panel open to new patients), or increase the size of their practices.

"Having a robust network is a priority for us, so we set out to be the best payer in the marketplace. As an outgrowth of Pennsylvania's risk-adjusted payment model for MCOs, which aligned our capitation rates more closely to the health status of the population we serve, we were able to enhance our provider payment rates to retain and recruit providers. We increased our base PCP capitation rates, incorporated capitation enhancements for meeting specified criteria such as extended office hours, *and* created an incentive pool to reward physicians who met other standards, such as generic use rate. For specialists, we already paid more than MA FFS, but we looked at fees by specialty and took everyone up somewhat – but more for certain specialties such as those with the medical malpractice rate problem. We're now paying 120-132% of the MA fee schedule."

c. MCOs regularly perform and respond to network analyses

MCO analyses of provider networks are conducted on two levels. Plan-wide analyses assess whether members have access to appropriate providers and whether access standards (e.g., travel time and distance) are being met. Provider participation in both urban and rural areas is analyzed, and year-to-year comparisons of provider networks are studied to monitor improvements. A more detailed level of provider network analysis occurs when MCOs conduct a drill-down analysis of provider access and needs on a county or zip code basis. Using county level analyses, MCOs identify particular geographic areas or provider types where network development activities could be targeted. MCO staff also meet regularly to identify network needs and discuss any access issues with contracted providers.

For example, one MCO operating in the Lehigh/Capital region responded to information regarding the provider network obtained from a member survey by performing a subsequent drill-down analysis. The findings served as a catalyst for targeted recruitment in specific areas in the provider network identified as in need of improvement. The same health plan surveys PCPs and asks them to identify the specialty areas most in need of network improvement and factors that information into its provider recruitment strategy.

One Southwest region MCO has contracted with dental schools in Pittsburgh and the Children's Hospital dental clinic in order to improve its dental network. Another MCO began a systematic and very intensive recruitment effort to increase the size of its dental provider network. The recruitment initiative has involved contacting literally hundreds of dentists in the service area and keeping a log of each contact. Through this effort, the MCO has recruited twelve new dentists since July 2004, increasing the size of its dental network by over 10 percent. This example illustrates how difficult it can be to improve access and the depths of efforts the MCOs have been willing to undertake. The same MCO has an initiative to increase their orthopedic provider network.

Certainly, some factors affecting access are not easily controlled. For instance, one state included in the GAO report noted that "the supply of physicians is severely limited in some states and in some regions of the state, affecting all payers, including commercial payers as well as Medicaid and SCHIP." While the GAO agreed that provider supply is an important determinant of access and can be difficult for state programs to address, the authors had this to say: "However, the type of monitoring activities addressed in this report can help to identify such factors and areas or locations where problems may be more pronounced, thus leading to more targeted solutions." It is evident that the HealthChoices MCOs are engaging in such monitoring and creatively addressing identified problems.

"In one of our more rural areas, there simply were no orthopedic specialists. We approached the hospital in the area with the idea of creating an orthopedic clinic. Through a creative reimbursement arrangement, whereby the plan reimburses the hospital for the technical component of clinic services and the physicians for the professional component, we have helped fund the clinic. Such partnerships—and this type of innovation—are hallmarks of the HealthChoices model that just don't happen very easily in the FFS setting."

d. MCOs are improving provider participation in Medical Assistance

MCO provider recruitment activities have accomplished more than just strengthening plan networks through contracting with providers who already participate in the MA FFS program. In many cases, the providers recruited to HealthChoices MCO networks are agreeing to accept Medical Assistance for the first time. In other cases, providers who previously stopped accepting Medical Assistance are returning to the program. Efforts to recruit new providers include looking at hospital physician directories, physician referral patterns, and repeated member requests for specific non-participating providers.

“We process from 75 to 80 physicians applications a month, many from physicians who do not have MAID numbers.”

“We have pending applications from a group of eight physicians in York County and three in Carbon County. They’re waiting to get through the MAID process. The state is aware of the situation and is working through the process, but it’s slow-going – even though the state’s criteria for approving an application are less stringent than ours.”

“A predecessor plan had a rule – if you participate in one line of business with us, you have to participate in all. Also, we have a lot of university contracts, and those have brought in a lot of physicians who previously weren’t accepting MA.”

e. MCOs cultivate their relationships with providers

Each of the HealthChoices MCOs operates a fully-staffed provider relations department that includes field representatives who spend much of their time on-site in providers’ offices. These departments are generally quite large (e.g., one MCO employs 33 field representatives and an additional 20 provider phone-line representatives). Such an infrastructure assures that provider recruitment is an ongoing activity that does not end when the MCO has a “sufficient” network (e.g., one MCO reported that they had brought in 10 new providers the previous week). However, in addition to engaging in continuous recruitment efforts, these staff service contracted providers, assisting them with any questions they may have and facilitating their compliance with contracts.

Each MCO offers a provider services hotline during regular business hours to assist providers with member eligibility, prior authorization and referral, claims payment, medical records, and other related issues. MCOs take additional steps beyond the minimum state requirements to improve provider hotline service. Such approaches that MCOs have taken include having a person answer provider service hotlines rather than an automated phone answering tree, assigning specific provider relations representatives to individual providers so that the providers have one point of contact at the MCO, and having a dedicated provider relations specialist for hospitals. Provider service staff receive initial and ongoing training, and the MCOs publish a provider manual annually.

MCOs also make additional services available to providers such as training and education, and encourage provider participation in other value-added activities. The following are just a few examples:

- MCOs in all three regions prepare profiles of physician performance. Some of the profiles compare individual physician performance to their peers on a variety of indicators.
- One MCO sends PCP reports of patients who make frequent visits to the emergency room and the reasons for the visits, as well as the emergency room usage of patients with migraines.
- In an effort to assist physicians in ensuring their panels receive needed services, another MCO sends providers a roster of members who have been identified as having diabetes,

asthma, or heart disease and found through claims analysis to lack appropriate medications and/or medical screenings.

Provider feedback is solicited through periodic provider surveys, and participation is also solicited through the various committees convened by MCOs. MCOs have several committees that meet to discuss a variety of issues including work groups to address targeted disease initiatives (e.g., diabetes, congestive health failure, and NICU) and physician profiling activities.

The MCOs' commitment to building and fostering relationships with providers no doubt assists with recruitment and retention efforts (as illustrated by the examples in the box below), and in turn enhances access for members.

One MCO's Quality Improvement Committee recommended termination of a physician as a result of quality concerns stemming from the physician's large number of malpractice cases. Interestingly, the physician's partner then applied to become a participant because he was impressed with the respect, dignity, and fairness with which the MCO had handled a difficult situation.

In another example, large pediatric practices had terminated their contracts with the MCO, creating deficiencies in the network. The MCO's unit responsible for network development contacted the providers to encourage them to continue participation in the network. After discussing solutions to the providers' concerns, both practices agreed to participate in the network again.

C. Helping Recipients Locate Providers Who Will Accept Them

Because provider participation in Medicaid – regardless of the delivery system model – has always been limited compared to participation in Medicare and commercial programs, recipients often find it difficult simply to find a provider who will accept them. In this section, we discuss what assistance is provided to recipients in this regard within each of the health service delivery models.

1. Fee-for-Service Program

In Pennsylvania's unmanaged FFS program, it appears that very little is done to provide information to recipients regarding participating physicians. The "Fee-for-Service Consumer Handbook" posted on the Department of Public Welfare's website does include a brief section entitled, "How Do I Find a Doctor?" (see box below).

HOW DO I FIND A DOCTOR?

As a Fee-for-Service consumer, you may select any doctor or provider (such as a hospital, pharmacy, home health agency, etc.) as long as they agree to treat you and are enrolled in the Fee-for-Service Program. The MA Program does not pay non-participating providers or make payments to you to pay the provider directly.

NOTE: If you are treated by a non-participating provider, you are responsible for the payment.

If you need help to find a participating provider, contact your local CAO and ask for the "MA Cares" list of providers in your county who participate in MA.

NOTE: Ask the provider if he or she accepts MA before you get treatment.

- excerpted from DPW Office of Medical Assistance Program's "Fee-for-Service Consumer Handbook" -

Recipients are advised to contact their local County Assistance Office (CAO) and ask for the “MA Cares” list of providers in their county who participate in MA. However, it appears that CAOs’ attention to the provider lists is inconsistent at best. In many cases, CAOs are unaware of the provider lists and believe that if such a list exists, it probably has not been updated for some time.¹⁴

DPW has incorporated certain enhancements into the ACCESS Plus program¹⁵ that it hopes will improve Medical Assistance recipients’ ability to find providers. For instance:

- The state’s ACCESS Plus contractor will be required to develop and maintain a website that includes a homepage for enrollees. Homepage information will include PCP directories, including limited English proficiency and ADA accessibility for PCP offices.
- The contractor is required to maintain a call center in Pennsylvania with a toll-free line for enrollees to address issues related to the ACCESS Plus program, to be staffed at least 7:00 am to 8:00 pm Monday through Friday, and from 10:00 am to 2:00 pm on Saturdays. Call center functions will include forwarding calls from enrollees who need to select a PCP to the state’s Enrollment Assistance Program (EAP) contractor. A number of call center requirements and performance standards have been outlined for ACCESS Plus, including a lost/abandoned call rate of no more than 5% and no greater than three minutes’ hold time.
- The contractor will be required to develop three PCP directories, including a hard copy, an online directory, and an electronic directory for the EAP contractor. These will also be distributed to the CAOs.

The contractor will also be required to identify MA program enrolled providers and whether they are accepting new MA recipients.

2. HealthChoices Program

The HealthChoices MCOs are required to have written policies and procedures for new member orientation, including benefit orientation and educational programs. All new members must receive a member handbook within five business days of enrollment, and a provider directory must be available for all types of providers within the MCO’s network. The provider directory (along with the member handbook) must be available in Braille, large print, and audio tape. In addition, the MCO contract requires that all member materials must be provided in languages other than English if five percent or more of the Medical Assistance consumers in a county speak that language.

Each of the MCOs meets the requirements for member materials, including the provider directory. The MCOs’ provider directories include all provider types (i.e., PCPs, specialists, ancillary providers, etc.) and provide information about the providers’ office hours (for PCPs),

¹⁴ The Lewin Group called several CAOs and never found evidence of a working provider list. When asked how recipients determine who participates in MA, several responded that “they probably just call the doctor’s office and find out.” In another instance, we were referred to another office and given the telephone number, but repeated calls all got a busy signal.

¹⁵ The requirements listed are contained in the ACCESS Plus draft agreement.

languages spoken, and accessibility. In addition to the required provider directory, a number of the MCOs maintain or plan to implement web-based, searchable on-line provider directories. These enable members to specify criteria (e.g., distance from their home, language spoken, gender preference, hospital where admitting privileges, specialty) and search for providers who meet those criteria. The member can print the customized directory or provide the criteria to the member services department via the plan's member phone line and have a customized directory mailed to them.

In addition, the MCOs are required to maintain and staff a 24-hour, seven-day-a-week toll-free dedicated hotline to respond to beneficiary inquiries, issues, and problems. The MCO call centers must be staffed with adequate service representatives to ensure standards relative to abandonment rate, hold time, busy rate, and answer time (similar to the standards set for ACCESS Plus) are met. In general, there do not appear to be problems with MCOs' ability to meet or exceed these standards. At least some of the MCOs have bettered the call answer time standard of 30 seconds for six or more months during 2004, answering member calls in half that time. Similarly, MCOs have performed better than the standard for call abandonment (5% or less), in some cases with call abandonment rates as low as 1.2%. In addition to the other services provided through the customer service line (discussed in a section to follow), the hotline assures around-the-clock assistance with finding appropriate providers.

"Ms. Beer continued that, back when she was on public assistance, there was no managed care and when HealthChoices was implemented, it was such a blessing. There used to be a problem finding doctors that would see MA patients, but managed care made this all possible."

- Excerpted from Minutes of the March 10, 2005 Managed Care Delivery System Subcommittee (a subcommittee of DPW's Medical Assistance Advisory Committee) meeting. Ms. Beer, a former MA recipient, is a member of the subcommittee and represents the Armstrong County Low Income Rights Organization.

D. Ease of Accessibility

Availability of providers does not necessarily assure accessibility, particularly for a population that faces transportation and other challenges. This section describes specific network characteristics and requirements regarding geographic distribution, travel time, appointment waiting times, and the like. In the next section, we turn to the "hands-on" efforts undertaken in the various models to further facilitate access.

1. Fee-for-Service Program

The unmanaged FFS program neither has requirements relative to the structure and location of participating providers' practices, nor does it monitor the availability of the MA "network."

Under ACCESS Plus, however, a few standards have been delineated that may contribute to enrollees' ability to obtain primary care:¹⁶

- The ACCESS Plus contractor must develop its PCP network with consideration of the “geographic location of PCPs and Enrollees, considering travel time consistent with that of the general public, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities.”
- The panel size limit is one (1) full-time ACCESS Plus PCP to 1,000 enrollees. (Presumably, panel size limits help to ensure that providers will have sufficient appointment availability, etc. However, such limits do very little to enhance or protect access unless physicians serve no patients in addition to their Medical Assistance patients.)
- The contractor must inform PCPs of their obligation to be ADA compliant and must visit a sample of PCP offices during the second year to confirm ADA accessibility.
- Certain non-specific scheduling requirements have been delineated, e.g., routine appointments and health assessments/general physical exams “must be scheduled within a reasonable timeframe.”

2. HealthChoices Program

The HealthChoices MCOs must adhere to scheduling and other PCP network requirements that are much more specific than those imposed on the ACCESS Plus program. For instance:

- Each member must have a choice of at least two PCPs within a travel time of 30 minutes (urban) and 60 minutes (rural).
- Emergency medical condition cases must be seen immediately or referred to an emergency facility, and urgent medical condition cases must be scheduled within 24 hours.
- Routine appointments must be scheduled within ten business days.
- Health assessment/general physical examinations and first examinations must be scheduled within three weeks of enrollment.
- The average office waiting time can be no more than 20 minutes, or at any time no more than one hour.

With respect to specialty care, the MCO networks must include adult and pediatric specialists in sufficient numbers to ensure that specialty services are made available in a timely, geographically, and physically accessible manner, particularly for members with special needs. Members must have a choice of at least two appropriate specialists or subspecialists who can meet their specific needs. Further, the

“Prior to the roll-out of mandatory managed care, a large proportion of Medicaid beneficiaries chose to enroll in our plan for increased access to specialists.”

¹⁶ Commonwealth of Pennsylvania, Department of Public Welfare, RFP No. 24-04 – Enhanced Primary Care Case Management and Disease Management Services

MCO must assure that routine specialty appointments are available within 10 days of referral, and that prenatal care appointments meet specified timeframes. The development and maintenance of a specialist network is a key advantage of the HealthChoices program compared to the other models.

The MCOs must also ensure a choice of at least two hospitals within the network, with at least one within the travel time limits (30 minutes urban, 60 minutes rural). All of the MCOs have very expansive hospital networks, with all or almost all of the hospitals in their geographic zones participating. In addition, it is not uncommon for the MCOs to enter into contracts with hospitals outside of their zone and/or out of the state that are sometimes utilized by members in emergency situations, for instance.

There are numerous other requirements related to other types of providers, e.g., the MCOs must provide members a choice of at least two general practice dentists, two rehabilitation facilities, two durable medical equipment (DME) suppliers, two home health agencies, and two pharmacies within the specified travel time limits (30 minutes urban, 60 minutes rural). In addition, the MCOs are accountable for inspecting PCP and dentist offices to determine whether they are compliant with the Americans with Disabilities Act (ADA). In some cases, MCO staff conduct site visits at provider offices during the credentialing process or during complaint investigations to ensure that safety and ADA requirements are met.

It should be noted that while these requirements appear fairly straightforward, at the time of contract procurement the proposing MCOs must not merely state that they will comply with these requirements; rather, they must demonstrate *how* they will meet the requirements by describing in detail their approaches. In responding to the state's Requests for Proposal, the MCOs compete on how well they illustrate their understanding of, and approach to, a variety of issues such as cultural competence.

Cultural Competence

The benefits of culturally competent providers regarding enhancing access to health care services are well documented. The PH-MCO should ensure that provider networks represent the racial and ethnic diversity of their members and their neighborhoods.

Both the PH-MCO and participating providers must demonstrate cultural competency and must understand that cultural differences (between provider and member) cannot be permitted to present barriers to accessing and receiving quality health care; willingness and ability to make the necessary distinctions between traditional treatment methods and/or non-traditional treatment methods that are consistent with the member's cultural background and which may be equally or more effective and appropriate for the particular patient; and the demonstration of consistency in providing quality care across a variety of cultures. For example, language, religious beliefs, cultural norms, social-economic conditions, diet, moral code, etc., may make one treatment method more palatable to a patient of a particular culture than to another of a differing culture.

- excerpted from *HealthChoices Southwest Physical RFP #10-97*

E. Facilitating Access Through Specialized Member Services, Enabling Services, Outreach and Other Mechanisms

This section focuses largely on the wide array of activities and initiatives the HealthChoices MCOs engage in to address the myriad barriers MA recipients often face that interfere with their ability to obtain appropriate services. Certainly, no such activities take place in any organized way (if at all) in the FFS system. While the ACCESS Plus program does include vendor contractual requirements regarding such things as oral interpretation services, culturally sensitive outreach approaches, and the like, the requirements are rather vague. Certainly, ACCESS Plus will no doubt result in vast improvements over the unmanaged FFS system, and given that some portion of the MA population may always remain in the FFS system (e.g., those in highly rural areas and beneficiaries in certain eligibility categories), the value of such a program is indisputable.

However, what the HealthChoices MCOs provide in the way of outreach and access facilitation is quite remarkable, and it is important that the added value they bring to the MA program become more understood by the policymaking community (and perhaps even by the broader population), which often seems to hear only negative stereotypes about the HMO coverage model. For those unfamiliar with the best of what Medicaid managed care has to offer, Medicaid MCOs are often viewed as “insurance companies” and little more. The information presented in this chapter thus far at least hints at the much broader role the HealthChoices MCOs play. The remainder of this chapter, and the other chapters in this report, should provide convincing evidence that, in many ways, the DPW and its contracting MCOs have achieved an ideal public/private partnership.

"I was recruiting a physician for our network and he sort of brushed me off saying 'you guys are just another insurance company.' That became sort of a rallying cry in my mind from that day on. Like heck we're just another insurance company. We go so far beyond traditional insurance company activities here that we actually bear very little resemblance at all to that type of setting. But it's one thing to know it and live it and another thing to make others aware of what we do and what we're really all about. That's where we seem to be having difficulty and where we're hoping your report can be of help."

The HealthChoices MCOs, across the board, provide a range of benefits and services above and beyond what is required. There are a variety of reasons for this; the following are the most notable:

- The MCOs have a competitive desire to attract and retain members. In fact, the motivation to compete appears to go beyond member growth. The Lewin Group was impressed during our site visits by the intense desire among MCO management to “be the best.” As an executive at one MCO stated, “We’re always thinking about what we can do better, what initiative we can implement next, what new innovation we can bring to improve quality and access for this needy population.” While the relationship among the health plans is very collegial and often collaborative, all of the MCOs appeared very interested in how they compared with the other plans – not financially or in size, but in terms of creative and effective approaches they have implemented. In our view, this is

one of the most significant benefits a Medicaid managed care system such as HealthChoices has to offer; this mindset fosters continual and likely more rapid advancement of the state's program objectives than would otherwise occur.

- The staff interest in serving this population is genuine and strong. As will be discussed later in this section, staff not only are committed to performing their jobs well, but they also give a remarkable amount of their personal time and resources to help the communities and individuals the health plans serve.
- The health plans also see it in their financial interest to “go the extra mile” to assure access to and appropriate utilization of services. They believe that the extra investments they make to help keep members healthy, and to identify and treat problems early and effectively when they do arise, are outweighed by the avoidance of costly health problems in the long run.

It is impossible in this section to lay out all of the access-enhancing activities and initiatives the MCOs engage in, so we present a sampling of activities that occur within various categories. First, however, we provide a brief overview of the typical member services function in the HealthChoices MCOs.

1. Overview of the member services function

The member services function is perhaps the area in which Medicaid managed care differs most markedly from managed care for commercial populations. To be effective, member services programs must be more proactive and more extensive than traditional member services activities. For this high-need population, the availability of a broad health care network must go hand-in-hand with a strong member education and outreach program designed to inform and *assist* Medicaid members regarding the appropriate use of a health care system that seeks to coordinate their care.

HealthChoices MCO member service activities include but are not limited to operation of an around-the-clock member services phone line; design and distribution of member materials tailored to the population; face-to-face interaction with members (including during member “walk-ins” and home visits); new member welcome calls and orientation programs; and ongoing member outreach. The MCOs employ committed, experienced and culturally-sensitive staff to perform these functions, many of whom are from minority and culturally diverse backgrounds and thus have a direct, personal understanding of the cultural issues and challenges faced by the HealthChoices members. The staff also includes a large number of former welfare recipients and of multi-lingual individuals.

The following sample statistics and descriptions regarding the HealthChoices MCOs' member services function, and the subsections to follow, help to illustrate the importance placed on this function and the vast array of value-added services the MCOs provide.

- One MCO's member hotline staff includes 38 FTEs from 8 am to 8pm, Monday through Friday. During non-peak hours (8pm to 8am and weekends), 14 FTEs are available. In addition to these staff, member services staff trained to answer pharmacy-related member questions are available. Another MCO has 43 member services representatives

and receives 21,000 to 25,000 calls per month. The unit also services “walk-ins,” of which there were 3,121 in 2004.

- All of the health plans invest time and resources in training and maintaining high quality staff. In one MCO, staff receive 8 weeks of training, including management orientation, managed care, product training, system training, customer services skills, and on-the-job mentoring. Training in all of the MCOs is ongoing, e.g., staff in one MCO attend monthly call center and team meetings, including monthly performance feedback for production, quality, and call observation.
- The MCOs monitor quality of the member services function and invest in approaches to enhance quality. One plan operates a Help Desk for member services representatives. Member services representatives can call the internal help desk for assistance with member questions, if needed. Call management systems include real-time monitoring of the system and answering times, and provide forecasting for staff loads. Internal quality audits are conducted of the member hotline, and one plan is piloting a project with an external vendor to follow up with members to obtain feedback on experience with member service hotline.

While much of the discussion above centers on the member hotline function of MCOs, the members services function goes well beyond operating a “call center,” as described in the remaining subsections.

2. *Language/interpretation/literacy services*

- Several of the health plans include Spanish-speaking staff on their member services hotline, and some have staff that speak other languages as well. For instance, one plan has in-house staff with language capability in the following languages, in addition to English: Russian, Cambodian, Vietnamese, and Spanish.
- One health plan pays for its member services staff to attend Spanish language classes at the local community college.
- Some of the MCOs have established a separate queue for Spanish-speaking members when they call the member hotline.
- One plan conducts an accessibility study focusing on Spanish-speaking PCPs, because they want to assure that Spanish-speaking members have a choice of at least two Spanish-speaking physicians within the travel time standards.
- Interpretation services (e.g., through the Language Line) are available within all of the MCOs.

Highlight: Health Literacy Program

One MCO operates a Health Literacy Initiative within its community service unit. The MCO partnered with community-based organizations to educate community members about health literacy and to collaborate on the development of health literature appropriate for all audiences. Through this initiative the MCO has worked to improve provider awareness of the existence and causes of low health literacy and to educate members on how to become better health care consumers. MCO staff developed an interactive presentation and have been invited to speak at several regional and local conferences. After developing the program, the MCO developed and conducted interactive workshops educating consumers on topics such as how to speak with their physician and get the most out of the visit to their doctor or how to take and store medications. The MCO also distributed information at health fairs and community events and paired with Eli Lilly to include health information on the health plan website. The next step in the health literacy program is to target specific health conditions and create workshops to encourage consumers to take a more active role in their health care.

3. Member incentive and other programs to encourage use of preventive and screening services/healthy behaviors

- Many of the HealthChoices MCOs have implemented member incentive programs to encourage their compliance with treatment protocols or use of preventive services. These include prenatal care and postnatal care incentive programs in which, for example, new mothers are provided a free car seat if they have complied with the prenatal visit schedule; and baby carriers (e.g., Snuggly™) if they keep their postnatal appointments.
- One MCO implemented an initiative to encourage its female Southeast Asian members to obtain mammograms, as cultural issues had kept the screening rate particularly low for this segment of the population. The MCO asked members to gather at a provider's office, where they were transported to an area hospital to receive mammograms. The women also received educational materials in their native languages. The initiative's goal was to serve 25 women, but 42 actually were served. Based on the success of the effort, this may become a quarterly initiative.
- Another MCO offers members a fitness benefit to encourage healthier lifestyles. The benefit includes membership at the YMCA and a discounted rate for Weight Watchers participation.
- An MCO in the HealthChoices Southeast region conducts an annual Health Ministry Program for Women. Through this initiative, the MCO works with the faith-based community to provide women of color with a safe environment where they can explore various approaches that would assist them in gaining and living healthier lifestyles. The program focuses on the stresses that may trigger chronic health conditions such as heart disease, diabetes, cancer, asthma, and obesity.
- One MCO has enlisted the assistance of celebrity basketball coaches in a program to educate children with asthma and their families about asthma. The program incorporates basketball drills and instructions with professional coaches with education about managing asthma through appropriate use of medication, nutrition, and monitored exercise. Several HealthChoices MCOs have initiated efforts to improve access to care, especially dental services, by bringing care directly to the members.

Three health plans are operating mobile dental clinics in conjunction with area schools, or school-based dental clinics to bring dental services to children.

Highlight: Smiling Faces Pilot Program

Southeastern Zone HealthChoices MCOs are key participants in Philadelphia's Smiling Faces Pilot Program, a school-based dental program designed to help improve the oral health status of school children ages 6 to 9. The program is designed to enhance school-based dental screenings by bringing a dentist into the school with mobile dental equipment and digital x-ray capabilities. Each child will receive a comprehensive dental exam, a cleaning, fluoride treatments, and sealants. The dentist will create a treatment plan based on the findings at the time of treatment. Letters will be sent to the parent/guardian of the children with a recommended course of treatment and recommendation to see one of the participating dentists, either immediately, within 3 months, or within 6 months. A list of dentists is included in the letter.

The pilot is scheduled to take place during February and March of 2005 at the Lewis Elkin School at D Street and Allegheny Avenue. The focus is on the students in grades 1-4, as they should have their secondary molars. As of mid-January 2005, there were 400 correctly signed consent forms.

4. Member materials/reminder letters/postcards

Several of the MCOs have welcome and health education materials and approaches, in addition to the required welcome packet, for their members. For example:

- One MCO has several targeted welcome kits, including diabetes, asthma, congestive heart failure, smoking cessation, and heart-healthy materials. Ongoing educational and outreach materials are available for these same target audiences.
- One plan described its practice of calling new members within ten days of their enrollment into the plan. During the call, a plan representative reviews the health plan benefits, helps the member select a PCP if he or she has not already done so, and discusses the benefit package. The health plan indicated that its member services staff engaged in these calls from the plan's inception and that DPW subsequently adopted this practice as a requirement.
- One plan has a full-time vendor dedicated to contacting the parents of members under two years old to remind them to get the recommended immunizations and screenings and provide education on age-appropriate health and safety topics. Members receive a total of five contacts between birth and age two.

Because the MCOs can track member utilization of services, they also are able to provide reminder postcards and other assistance to ensure that appropriate services are being provided. Reminder activities reported by the plans include the following:

- Sending reminders to patients needing flu shots, immunizations, and diabetes screenings.

- Sending birthday cards and/or making telephone calls to members with age appropriate reminders for health care (e.g., dental care, immunizations, mammography).
- A variety of initiatives targeted to both providers and members to improve EPSDT rates. One plan creates EPSDT screening targets for providers with incentives for achieving goals. Providers successfully meeting goals receive free medical supplies. The MCO reports that it has successfully turned some high volume practices into high EPSDT screening offices. Another MCO sends regular letters to providers with reminders of EPSDT requirements and periodicity schedules, while others send rosters of child members who are due for an EPSDT screen. The roster provides information regarding the member's age, address, and next EPSDT screen due. MCOs also reach out to members and their families by mailing birthday cards that include a reminder about EPSDT or by making outreach calls to members who are due for screening.
- Specific materials targeted to women's health issues, e.g., women's health report cards that indicate date of last mammogram, cervical cancer screening; maternity program welcome kit, including a breast feeding guide.
- Calls from member services representatives to members who have experienced an acute event and whose discharge plans include durable medical equipment, physical therapy, occupational therapy, or home health, to assess whether the members are in fact receiving the needed services.

"Thank you for sending my grandson a brochure about why children shouldn't start smoking. I think it really made an impact on him and made him think twice about smoking. Sending it was a wonderful idea!"

- a member letter

"A member called to say thank you for the yearly pap smear reminder. Last year she received the reminder and found out at her check-up that she had cervical cancer. She said the letters do work and she appreciates our kindness."

The MCOs also produce member newsletters, which serve as vehicles for providing ongoing and health education on issues such as obesity and smoking cessation. Some plans also publish targeted newsletters, including one available on the Internet that targets the health plan's approximately 50,000 teenage members.

5. Individualized care management

Meeting the needs of the medically underserved low-income population, whose health can be adversely affected by the challenges of daily living, requires that the health plans address more than simply the members' health care. The care management approaches the HealthChoices MCOs engage in demonstrate their keen understanding that access to quality health care is only one component of good health, and that health care cannot be delivered successfully in isolation of the psychological, social, and economic factors that form the environment in which their members live.

Both individualized care management and disease management within the HealthChoices program are discussed in detail in a separate chapter in this report devoted to the accomplishments of the program in serving special needs populations. However, because addressing psychosocial and socioeconomic barriers help to ensure that members are able to access and obtain needed health services, we briefly touch upon care management here as well.

Below are some examples of the steps the MCOs take to ensure that members' needs in other aspects of their lives are being met:

- The MCOs help link members to community resources such as Area Agencies on Aging, food pantries, public housing, and YMCA/YWCA.
- During member needs assessments, the MCOs cover more than just physical health needs. One MCO described asking members about the psychosocial factors that can affect health and well-being, members' spirit and mood, housing issues, etc.
- One MCO has begun a domestic violence initiative. Each time a member call into the Member Services Hotline, the member services representative asks whether the member is safe at home. Members expressing safety concerns are linked with appropriate shelters and agencies.
- One MCO operates a mobile case management unit. An in-house case manager conducts assessments and education telephonically. If additional clinical or environmental information is needed from the member, the mobile team is deployed to the member's home for further assessment. The mobile team includes nurses, social workers and outreach representatives.

"In order to allow a one-year old baby suffering from Trisomy 21 to go home with his parents from the hospital, the case manager worked with community organizations to find the funding to rewire his home so it could support his needed ventilator and suction machine."

"A 49 year old man with multiple orthopedic traumas was able to successfully live independently while receiving all necessary medical care due to careful coordination of the nursing home he was leaving, a DME company, and a home health agency. He was able to receive a power wheelchair and physical therapy from an out-of-network provider."

6. Community involvement/special initiatives

The HealthChoices MCOs – as well as their individual employees – have undertaken numerous initiatives to invest in the communities in which their members live. While not neatly categorized as “access-enhancing,” these activities support the MCOs’ efforts to empower members by showing that “someone cares about them.” The services outlined below demonstrate the MCOs’ commitment and holistic approach to improving not only their members’ health, but also their well-being.

- Staff from one Southwest region MCO host an annual Christmas party for a local community. About 60 to 80 MCO staff volunteer to plan, host, and attend the party, which includes the participation of Santa Claus, presentation of gifts to children, and other party activities.
- MCO staff respond to specific member circumstances and act to fill a need. Several MCOs provide members in need with food baskets and toys for children during the holidays to help alleviate some of the stresses than can affect member well-being and compliance with treatment protocols. A HealthChoices Southeast MCO, in partnership with foundations, state waiver programs, and other available grants, works to help members in several non-medical areas, including buying cribs or paying electricity bills.

After a devastating flood, a member with four children, one with leukemia, was left homeless without any furniture or other possessions. The health plan heard about her plight and started a collection for her which included clothing, linens, and even bunk beds for her children who were sleeping on the floor in temporary housing. Employees from member services delivered the donations to the grateful member who could only cry and hug them.

A health plan member, a young boy who had been severely burned, was being discharged from the hospital. The health plan staff wanted to have a teddy bear and balloons delivered to his home, but could not find a store that would deliver to the boy's neighborhood. Instead of dropping the idea, two health plan members purchased and delivered the teddy bear and balloons themselves.

- Some of the HealthChoices MCOs have established foundations or programs to which employees can contribute financially and participate in the decision-making related to giving. MCO foundations support members by providing assistance with food, clothing, emergency relief (e.g., energy assistance, funeral expenses), and education. One MCO, for example, learned that many of its employees accumulated unneeded items at home (towels, clothing, etc.) and has created mechanisms for its employees to donate these items to enrollees at multiple times during the year. The employees of another plan reach out to member families in need during the holiday season. Employees donate their time and money to purchase, wrap and deliver presents to the needy families just in time for the holidays. Over the past few years, employees have provided holiday gifts and shared the season's joy with more than 100 families.
- The MCOs participate in scholarship programs for their members. One MCO has established a scholarship program which provides \$1,000 - \$2,000 scholarships to high-achieving student members in its service area. The MCO also supports a "perfect attendance" program at five local schools. Another has awarded nearly 300 educational scholarships to members, totaling nearly \$1 million, since 1988.

A blind health plan member became aware of and applied for a member scholarship benefit. The benefit provided funds for tuition, books, and a computer system enabling the member to earn an associate degree in Social Gerontology and to pursue a B.S. in Psychology, neither of which would have been possible without the scholarship.

- MCOs support local foundations that serve members of their communities, and many health plan staff hold numerous board memberships within community organizations. For instance, staff at one MCO in the Southwest region alone hold 85 board memberships in regional affiliates of national organizations as well as in community-based organizations. The MCO also participates in a wide range of organizations related to children's health, social services, rural health, and education, as well as industry associations.
- MCOs also serve the community by offering a variety of "life skills" classes at local sites. For example, one MCO provides a computer literacy program to assist members and others in the community to gain basic computer skills and to prepare resumes. The community demand for the computer literacy program has been so great that the number of training sites has grown to 24 and the MCO has provided 2,855 classes to a

total of 5,332 students. Nearly 500 of the students have since become employed. As part of the training, individuals are taught to use health care web sites. Other classes such as parenting, personal hygiene, understanding health care, health promotion, and emotional well being are also available, and classes are offered at no charge.

- One MCO operates a satellite office at a community mall. In addition to attending computer literacy, parent training, and other classes at this site, members and other community residents can drop into the site and obtain assistance in completing fuel applications, etc.
- MCOs run or participate in numerous community health fairs and events. Health fairs and events occur at a variety of sites such as schools or churches and cover a wide range of topics. Families can obtain information about specific health conditions, the benefits and strategies for achieving healthier lifestyles, and linkages to other community-based programs to help satisfy their non-health related needs. Often the events are targeted the aged, specific ethnic/racial populations, or those in more rural parts of the service regions.
- One MCO described how it also conducts community health education programs by request. Community-based organizations can request the MCO to conduct a program in a number of wellness, safety, and health topic areas such as: nutrition, managed care, healthy hearts, smoking cessation, obesity, and women’s and men’s health topics. One program on fire, burn, and scald prevention reached more than 3,000 individuals. This program was honored by the Pennsylvania Rural Health Council as Program of the Year.
- A Southwest region MCO described its outreach events for providers in its network. The MCO coordinates a meeting of network providers during which the health plan medical director speaks to physicians about a variety of topics such as improving pediatric immunization rates. Conducting provider-oriented events helps to keep providers engaged in MCO initiatives, helps providers to network with each other, and helps promote member access to timely and high quality health care services.

One MCO broadcasts an audience participation show over the public housing cable network in which participants can “Ask the Doctor” questions about health and safety topics.

F. Concluding Remarks

Certainly, access has been and continues to be a broad, multi-faceted problem for low-income and other special needs populations. The discussion in this chapter is not meant to suggest that any model of care—including the capitated Medicaid managed care model—is a panacea. Despite the efforts undertaken, overcoming the hurdles that the Medicaid population faces to enhance access is a painstaking process.

However, at its best, capitated Medicaid managed demonstrates superior capability with respect to creating and delivering access to health care services. As has been discussed, certain issues that contribute to access problems simply cannot be addressed by the FFS system. And

while it is *possible* that a managed FFS model could replicate much of what occurs in the managed care model, the ongoing ability of any state to secure explicit funding for the various “administrative” functions MCOs perform is questionable. Further, the ability of the managed FFS model to match the MCOs’ local presence cannot realistically be expected to occur.

Earlier, we made reference to “the best of what Medicaid managed care has to offer.” Based on The Lewin Group’s site visits to the HealthChoices MCOs and review of available information and data, we sincerely believe that Pennsylvania is fortunate to have in its Medical Assistance managed care program some of the best of what this model of care can provide. We have been impressed not only by the efforts of the HealthChoices MCOs; we are equally impressed with the state’s design and oversight of this program. Certainly, there are always things that can be done better, and new approaches that can be adopted. As we also stated earlier, the MCOs appear strongly motivated to continue enhancing the value and effectiveness of the model.

IV. QUALITY ASSESSMENT

A. Introduction

After the introduction of the Medicaid program in 1965, FFS remained the predominant, if not only, Medicaid program model. In the early 1990s, however, the federal government began to encourage states to adopt managed care models by easing regulatory requirements, in hopes both of increasing the cost-effectiveness of the program and of addressing the many barriers to access and quality that had become apparent. States quickly embraced the managed care model as an opportunity to introduce accountability into the Medicaid program; within a decade, 58 percent of the nation's forty million Medicaid beneficiaries were in some form of managed care program.

While the potential for enhanced quality was part of the impetus for the growth of Medicaid managed care, both proponents and critics of the model have continued to emphasize the need for aggressive quality management and oversight by state Medicaid agencies of capitated Medicaid managed care programs. Specifically, CMS requires states to develop and implement a "quality assessment and improvement strategy" that includes procedures for monitoring and evaluating the quality and appropriateness of care and services. State Medicaid agencies must also ensure that, with respect to each Medicaid MCO with which they contract, an external quality review organization conducts an annual independent review of the quality and accessibility of Medicaid services provided under the contract. States also attempt to ensure quality by specifying minimum contractual standards for the MCOs.

A general focus on quality and quality monitoring are far less integral components of the PCCM model compared to the capitated health plan model. A recent study on quality oversight in Medicaid PCCM programs found that the majority of Medicaid PCCM programs are not yet using the quality measurement, feedback, and improvement strategies that are often required of MCOs. Even states that operate both PCCM and MCO programs seemed to have fewer expectations of the PCCM program. Similarly, FFS programs conduct minimal quality oversight.¹⁷

Several factors could limit collection and reporting of clinical performance data in PCCM programs. First, states may lack the budgetary resources to implement effective PCCM programs; resources may instead be diverted to expanding the eligibility to beneficiaries who might otherwise lack coverage altogether. Second, state agency PCCM programs lack a national quality oversight organization, like the National Committee for Quality Assurance (NCQA), which could standardize and motivate data collection and reporting on quality. Third, PCCM programs may lack needed expertise. Our results show that PCCM programs are younger on average than their HMO counterparts. With greater experience, these organizations may become more active in the quality monitoring role.

Quality Oversight in Medicaid Primary Care Case Management Programs, Health Affairs, November/December 2004

The remainder of this chapter focuses on the quality related requirements for HealthChoices and ACCESS Plus, key quality measurement tools in Medicaid, quality initiatives underway in the HealthChoices program, and an overview of the investment required to run a quality management program.

¹⁷ Quality Oversight in Medicaid Primary Care Case Management Programs, Health Affairs, November/December 2004.

B. Required Quality Elements in HealthChoices and ACCESS Plus

In Pennsylvania, DPW has required many of the same activities of the ACCESS Plus contractor that are required of the MCOs, as outlined below. However, the MCOs have several years of experience with quality management and improvement for the Pennsylvania Medicaid population, and are able to build on their quality monitoring activities to design and implement quality improvement strategies.

1. Contractual Requirements for ACCESS Plus and HealthChoices

There are several quality standards that the HealthChoices MCOs and the ACCESS Plus contractor are required to meet:

- The scope of the quality management (QM) program must be comprehensive in nature, and allow the program to improve health outcomes and satisfaction for the enrollees. This includes, but is not limited to, assessment of barriers of care, quality of care, care coordination and continuity of services.
- The organization structure of the HealthChoices MCOs and the ACCESS Plus contractor must ensure one Governing Body and Quality Management Committee to oversee the QM activities.
- The QM program must include methodologies that allow for the objective and systematic monitoring, measurement and evaluation of the quality, appropriateness of care and services provided to enrollees through quality of care studies and related activities, with a focus on identifying and pursuing opportunities for continuous and sustained improvement.
- The QM program must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided to members through utilization review activities (only required for HealthChoices MCOs).
- The HealthChoices MCOs and the ACCESS Plus contractor must develop mechanisms for integration of disease and health management programs that rely on prevention of complications as well as treatment of chronic conditions for enrollees identified through clinical and financial analysis of claims data, enrollee demographic information, and utilization patterns.
- The HealthChoices MCOs and the ACCESS Plus contractor must have mechanisms to assist enrollees and to ensure that members receive seamless, continuous, and appropriate care, by means of coordination of care, benefits, and quality improvement.
- The HealthChoices MCOs and the ACCESS Plus contractor must have formal accountability for the QM program.
- The HealthChoices MCOs and the ACCESS Plus contractor must have standards for credentialing and recredentialing PCPs to determine whether providers who are licensed by the Commonwealth are qualified to perform their services.
- The MCO must have a mechanism in place for provider appeals, while the ACCESS Plus Contractor must have policies and procedures for referring provider complaints to DPW.

- The HealthChoices MCOs must ensure that findings, conclusions, recommendations, and actions taken as a result of the QM program activities are documented and reported to appropriate individuals within the MCO for use in other activities. Similarly, the ACCESS Plus Contractor must have written policies and procedures for record keeping on all of the Contractor activities.
- The HealthChoices MCOs and the ACCESS Plus contractor must have policies and procedures for written standards for medical record keeping.
- The QM program must demonstrate a commitment to advocate that enrollees are treated in a manner that acknowledges their defined rights and responsibilities.
- The HealthChoices MCOs and the ACCESS Plus contractor must maintain systems that document implementation of the written QM program descriptions.

Certainly, DPW has given considerable thought to designing the ACCESS Plus program, and many of the requirements are modeled after successful managed care programs. Although many of the contractual requirements are the same for the HealthChoices MCOs and the ACCESS Plus contractor, the MCOs have several years of experience with this population, have experience in reporting quality indicators to DPW, and have built valuable relationships with stakeholders throughout the community, including providers, case workers, and the other MCOs. Further, while the ACCESS Plus program builds in numerous quality-related requirements, they are not as extensive as the HealthChoices requirements, nor does the structure of the PCCM program support quality measurement and improvements as well as does the integrated system of care embodied by HealthChoices.

2. Additional Contractual Requirements for the HealthChoices Program

HealthChoices MCOs have several additional criteria that they are required to meet, beyond those described above. Generally, the MCO's quality management program must be designed to assure and improve upon the accessibility, availability, and quality of care being provided in its network. The scope of the program must be comprehensive in nature, and allow the MCO to improve access, availability, health outcomes, and satisfaction for HealthChoices members, including assessment of barriers to care, quality of care, care coordination, and continuity of services.

The MCO contracts have several quality management requirements, as outlined in the following section. Many of these requirements parallel those required in the ACCESS Plus contract. In addition to those requirements, the quality management program must:

- Include a written program description and annual workplan. Activities/ initiatives will be prioritized in partnership with DPW based on the External Quality Review (EQR) findings, Health Plan Employer Data and Information Set (HEDIS®) measures, and encounter data submitted by the MCO.
- On at least an annual basis, the MCO must cooperate fully with an external quality review. Each MCO must allow access to external clinical record reviews to assess quality of care, access to care, and timeliness of care.
- The MCO must submit HEDIS data and member satisfaction on an annual basis to DPW.

- Each MCO must participate and cooperate in the Medical Assistance Advisory Committee.

C. MCO Performance on Key Quality Measurement Tools

Each of the HealthChoices MCOs is accredited by the National Committee for Quality Assurance (NCQA), a private, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans. NCQA evaluates health care in three different ways: through accreditation (a rigorous on-site review of key clinical and administrative processes); through HEDIS -- a tool used to measure performance in key areas such as immunization and mammography screening rates); and through a comprehensive member satisfaction survey.

All seven plans participating in HealthChoices are accredited by NCQA, six with an excellent rating, one with a commendable rating. These are the two highest ratings for NCQA accreditation. To be awarded either

One of the Pennsylvania HealthChoices MCOs was recently named as one of NCQA's Top 10 Medicaid health plans nationwide.

the commendable or excellent rating, plans must demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. The excellent outcome (NCQA's highest) is awarded to plans that have also achieved HEDIS results that are in the highest range of national or regional performance.

1. HEDIS

HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes. As stated above, the HealthChoices MCOs' attainment of an "excellent" accreditation outcome means, among other things, that they have achieved HEDIS results that are in the highest range of national or regional performance. As just one example, the average score of the plans is well above the national average for Children's Access to Primary Care Practitioners, with selected plans performing near the 90th percentile.

HEDIS scores allow the MCOs to monitor care and track progress from year to year. The health plans have several years of experience with HEDIS data for the Pennsylvania Medicaid population, and they generally monitor trends over the previous three-year period. In Table IV-1 below we provide data on how the HealthChoices MCOs have scored, relative to the national median Medicaid HEDIS scores, in four key areas that are particularly relevant to the Medicaid population: immunizations, women's health, asthma, and diabetes.

- Immunization status for both children and adolescents is an area that receives considerable attention in Medicaid, particularly surrounding Early, Periodic, Screening, Diagnosis, and Testing (EPSDT) requirements. For the four combination measures of immunization rates for children and adolescents, the average HealthChoices MCO score is considerably above the national median benchmark.
- Women, particularly women of childbearing age, make up a large portion of the Medicaid population. For the four primary HEDIS measures related to women's health

(breast cancer screening, cervical cancer screening, prenatal care, and postpartum care), the MCOs have exceeded the benchmark.

- Appropriate use of medications for people with asthma is an important measure for the Medicaid population, where the prevalence of asthma is quite high. The MCOs not only have exceeded the benchmark, but score above the 90th percentile for this measure across each of three age ranges.
- Diabetes is another key area for the Medicaid population, and the HealthChoices MCOs scored better than or very near the benchmark on five of six diabetes measures.

Table IV-1: HEDIS Performance Results, Across HealthChoices MCOs, 2003

HEDIS Measure	National Medicaid HEDIS Benchmark	HealthChoices MCO Average
Immunization Status		
Childhood Immunization Status Combination #1 (<i>Children who received four DTaP/DT vaccinations, three OPV/IPV vaccinations, one MMR vaccination, three HiB vaccinations and three hepatitis B vaccinations</i>)	59.6	66.0
Childhood Immunization Status Combination #2 (<i>Children who received all of the vaccines in Combination #1 and at least one VZV</i>)	55.6	64.2
Adolescent Immunization Status Combination #1 (<i>Adolescents who received the second MMR and three hepatitis B vaccinations as specified above</i>)	40.9	67.5
Adolescent Immunization Status Combination #2 (<i>Adolescents who received all of the vaccinations listed in Combination #1 and at least one VZV</i>)	20.8	49.9
Women's Health		
Breast Cancer Screening (<i>Women ages 50-69 who had a mammogram</i>)	55.8	58.7
Cervical Cancer Screening (<i>Women ages 18-64 who received one or more Pap tests</i>)	61.7	64.6
Timeliness of Prenatal Care (<i>Pregnant women who received a prenatal visit in the first trimester or within 42 days of MCO enrollment</i>)	74.1	84.2
Postpartum Care (<i>Women who had a postpartum visit on or between 21 and 56 days after delivery</i>)	55.0	63.1
Asthma		
Use of Appropriate Medications for People with Asthma, Ages 5-9 (<i>Members who were identified as having persistent asthma and who were appropriately prescribed medication</i>)	61.8	67.0
Use of Appropriate Medications for People with Asthma, Ages 10-17 (<i>Members who were identified as having persistent asthma and who were appropriately prescribed medication</i>)	63.0	66.6
Use of Appropriate Medications for People with Asthma, Ages 18-56 (<i>Members who were identified as having persistent asthma and who were appropriately prescribed medication</i>)	65.3	73.0

HEDIS Measure	National Medicaid HEDIS Benchmark	HealthChoices MCO Average
Diabetes Care		
Hemoglobin A1c Tested (<i>Members ages 18-75 with diabetes, type 1 and type 2, who had this test performed</i>)	77.3	75.1
HbA1c Poorly Controlled (<i>Members ages 18-75 with diabetes, type 1 and type 2</i>)	47.0	42.0 <i>(lower score is better on this measure)</i>
Eye Exam Performed (<i>Members ages 18-75 with diabetes, type 1 and type 2, who had this test performed</i>)	49.2	56.3
LDL-C Screening Performed (<i>Members ages 18-75 with diabetes, type 1 and type 2, who had this test performed</i>)	74.4	79.3
LDL-C Controlled (<i>Members ages 18-75 with diabetes, type 1 and type 2</i>)	45.7	38.2
Kidney Disease (nephropathy) Monitored (<i>Members ages 18-75 with diabetes, type 1 and type 2, who had this test performed</i>)	48.7	47.2

In deriving the Table IV-1 figures, we used MCO-reported HEDIS data from 2003 (data from one MCO is for 2004), and NCQA-reported percentiles from 2003. Data was available from six of the seven HealthChoices MCOs. The aggregated HealthChoices score is a straight average of performance across the six included health plans.

In addition to quality monitoring, health plans are responsible for designing and implementing quality improvement initiatives. In many cases, these initiatives address areas for improvement identified through HEDIS measurement. For example, one HealthChoices MCO measures the Frequency of Ongoing Prenatal Care (the percentage of pregnant women who received the expected number of prenatal care visits) and tracks the scores for the previous three years. Based on an analysis of these scores, the health plan implements interventions to increase the frequency of prenatal visits, such as case management initiatives, the annual distribution of pregnancy guidelines to all appropriate practitioners, and annual publication of normal pregnancy guidelines to all head of household members.

2. CAHPS

The Consumer Assessment of Health Plans (CAHPS®) is a nationally recognized set of consumer satisfaction surveys, which HealthChoices MCOs are required to field on at least an annual basis. The CAHPS surveys incorporate global measures of overall plan performance, including overall rating of personal doctor/nurse, overall rating of care received, overall rating of specialist, and overall rating of health plan. Other performance-related questions measure members' perceptions of getting needed care, getting care quickly, how well doctors communicate, courteous and helpful office staff, and effectiveness of customer service. The HealthChoices MCOs have consistently achieved high CAHPS scores, as demonstrated in Table

IV-2. On the composite and overall¹⁸ CAHPS measures of member satisfaction, the average scores for all health plans were above the 75th percentile (shown in italics in Table IV-2). Scores for four of the nine measures above the 90th percentile (shown in bold in Table IV-2).

Table IV-2: CAHPS Performance Results, Across HealthChoices MCOs, 2003

CAHPS Measure	Medicaid National 50 th Percentile	Medicaid National 75 th Percentile	Medicaid National 90 th Percentile	Average HealthChoices Performance
Rating of Personal Doctor or Nurse	2.44	2.50	2.54	2.55
Rating of Specialist	2.44	2.49	2.55	2.52
Rating of Health Care	2.33	2.41	2.46	2.50
Rating of Health Plan	2.34	2.41	2.48	2.46
Getting Needed Care	2.63	2.69	2.75	2.70
Getting Care Quickly	2.26	2.32	2.37	2.32
How Well Doctors Communicate	2.46	2.51	2.55	2.55
Courteous and Helpful Office Staff	2.56	2.60	2.66	2.64
Customer Service	2.52	2.60	2.70	2.70

In deriving the Table IV-2 figures, we used MCO-reported CAHPS data from 2003, and NCQA-reported percentiles from the same year. Data for 2003 was available from six of the seven HealthChoices MCOs. The aggregated HealthChoices score is a straight average of performance across the six included health plans.

Similar to HEDIS, the health plans use CAHPS results to prioritize areas for quality improvement, analyzing results to identify trends in performance, barriers, and opportunities. The MCOs also monitor measures from year to year, and set internal goals for improvement, such as achieving/maintaining NCQA HEDIS 90th percentile for accreditation scoring.

D. Pennsylvania Health Plans' Quality Improvement Initiatives

The HealthChoices MCOs have several years of experience in monitoring performance and developing quality improvement initiatives. Each MCO has a quality improvement work plan in place, which includes their objectives for quality-focused work and guidelines for development of studies to address specific quality issues. The quality improvement plan also focuses on continuous quality improvement, where results of quality improvement initiatives

¹⁸ Questions from the CAHPS® survey are used to calculate a set of six composites scores and four overall ratings which are then reported by health plans, and are used by NCQA for accreditation processes and report cards. Each composite score is made up of plan level aggregations of member responses to two or more CAHPS® questions.

are reviewed and analyzed by several departments within the health plan. Barrier analysis, identification of opportunities, and the development of interventions are performed through interdepartmental teams. The collaboration across multiple departments within the MCO broadens the scope of the review, expands the knowledge base of member, practitioner, provider, community, and internal issues, and therefore leads to more efficient use of resources and the development of a more effective plan of action.

The MCOs have policies and procedures in place to evaluate quality of care concerns, to provide a mechanism for investigating and resolving quality of care concerns. A quality of care concern is a situation where there is potential that the quality of the health care services provided to a member did not increase the likelihood of desired health outcomes, is not consistent with current professional knowledge, or the member's health or life may have been placed in jeopardy due to the action or lack of action taken by a practitioner. The MCOs have specific procedures in place to identify these problems, review the information and investigate the issue, assign a severity level, and make recommendations or take necessary action to resolve the issue.

MCOs have a great deal of flexibility in responding to any quality of care concerns that may arise. One ongoing formal process for monitoring quality of care within the MCOs is sentinel event reporting. The HealthChoices MCOs monitor sentinel events to insure that appropriate care is being provided and to realize any potential patterns of trouble for correction purposes. Sentinel events include certain hospital readmissions, surgical complications, and some member complaints. These events are able to be tracked through claims and utilization data and member services. When sentinel events are reported, the MCOs have a process in place to evaluate cases for potential issues with quality of care. The MCO will request member records as needed, and will forward the case to the Medical Director for further evaluation as indicated. The MCOs have a process to document and track cases, and to monitor for potential patterns of problems so that policies and procedures can be changed and updated as necessary. Ongoing monitoring allows the MCOs to evaluate and improve care on a more real-time basis, rather than waiting for annual reviews of quality indicators.

Typically, the HealthChoices MCOs develop their quality initiatives based on knowledge gained from quality monitoring activities and in-depth knowledge of their populations. For example, several of the MCOs have quality improvement initiatives focusing on prevalence of diseases and conditions within their membership (such as asthma or diabetes), utilization patterns (including both under and over utilization), DM (including asthma, cardiac, diabetes, and maternity care), and preventive health services (for children, women, behavioral health, smoking cessation, and domestic violence). The following are selected examples of quality improvement initiatives underway at the MCOs:

- **The MCOs conduct outreach and education activities to increase the rate of annual dental visits.** For example, one MCO has a quality improvement initiative focusing on increasing the rate of annual dental visits for members between the ages of 3 and 21 years. Each year, the MCO conducts a variety of activities to increase members' awareness of the importance of annual dental visits. Those activities include daily outreach phone calls to member and member newsletters to enhance their understanding of dental benefits and the importance of preventive dental care; post card

mailings to members with special needs to enhance their understanding regarding how to access appropriate dental care; targeted reminder post card mailings to decrease the high rate of failed or broken dental appointments; directly conducting dental screening activities in elementary schools; and letter mailings to eligible members age 3-20 advising them of the need for a dental visit. Besides the outreach and education efforts targeted to members, the MCO continues to improve the provider network accessibility and outreaches to its providers to increase awareness of the importance of preventive care. This MCO has faced two barriers in implementing this program. First, members are not fully utilizing the services available to them and are not taking advantage of the benefits provided by the health plan. Another barrier is a high “no show” rate. The MCO will continue its outreach efforts to the members to increase awareness and understanding by post card mailings, member newsletters, targeted outreach calls. Specific interventions as part of this project include:

- Daily outreach telephone calls;
 - Universal tracking database implemented;
 - Updated provider directory forwarded to the call center;
 - New dental director hired;
 - Reminder post cards; and
 - Pilot program dental screening performed for 1st, 3rd, and 4th graders at one school.
- **The health plans focus their efforts to improve prenatal care.** In July 2002, one MCO created the Baby Partners Prenatal Outreach Program as an intensive case management initiative to increase the proportion of pregnant women receiving prenatal care and improve overall birth outcomes by reducing rates of preterm and low birth-weight births. During the 12-month study period, 2,023 pregnant health plan members were referred to Baby Partners and 1,951 members enrolled in the program. Pregnant members received educational mailings and telephone outreach calls from registered nurses and social workers. The following interventions were performed: prenatal risk assessments; identification of medical, social, and nutritional needs; referral to support services such as smoking cessation counseling; arrangement of home-care visits and durable medical equipment; and assistance with transportation to physician offices. The program’s results were tracked and its success was demonstrated: 71 percent of enrolled members attended 61-100 percent of their prenatal visits. The number of preterm babies also decreased significantly, by 17 percent. The MCO’s Baby Partners program has improved the prenatal care and infant outcomes of the plan’s Medicaid population.

Another health plan assigned health coaches to certain pregnant members who will receive phone calls and home visits, and to help the expectant mother stay involved in activities to maintain her health and to maintain her baby’s well-being during pregnancy. The health coach can also assist the mother-to-be with identifying community resources she may need during pregnancy. The main focuses of the program include early and consistent prenatal care, smoking cessation, drug and alcohol treatment, and domestic violence screening.

- **MCOs devote resources to quality improvement and disease management programs focusing on asthma, a key area of concern for the Medicaid population.** In partnership with a group of seven federally-qualified health centers, one MCO operates “Healthy Hoops,” a program seeking to educate asthmatic children and their parents about asthma, and how to manage the disease through appropriate medication usage, proper nutrition, monitored exercise and recreational activities. With the guidance and supervision of celebrity basketball coaches and medical staff, the 2004 program included asthma control screenings, professional development, the Healthy Hoops Kick Off and the Fall Challenge. One hundred and eighty four children with asthma participated and received Spirometry screening at the Greater Philadelphia Health Action and St Christopher’s Hospital, of which 116 were MCO members. As a result of the program, emergency room visits decreased by 78% and nocturnal awakenings sleep disturbances decreased by 70%.
- **Decreasing “no-shows,” as a way to increase general health status, is a major focus for many Medicaid MCOs.** One MCO has a quality improvement project in place to improve the health status, including recommended immunization, of members turning age 2 and age 13 by reminding the parents/guardians of these members to schedule a PCP visit for the children. In addition to reminders, the MCO uses claims data to determine that a PCP visit had taken place. In cases where no PCP visit occurred, the MCO conducts outreach to all members age two years and thirteen years, in an effort to reduce future “no-shows.” Additional staff was added to accommodate the volume of calls and the activity was coordinated with EPSDT outreach calls. Results show that the percentage of PCP appointments kept was higher for members contacted by the MCO.
- **The health plans develop quality improvement projects based on quality monitoring activities, such as HEDIS or CAHPS.** Based on the 2004 CAHPS survey question regarding smoking, one health plan found that over 60% of the responding members smoked every day or some days, which is considerably higher than the national rate of 30% reported by the CDC. In an effort to reduce the high rate of smoking within its membership, the health plan has focused its efforts on encouraging members to quit smoking and to facilitating providers’ ability to assist members with counseling and prescription benefits for nicotine replacement products. The health plan conducted several activities, including:
 - Partnering with a pharmacy to provide smoking cessation classes;
 - Identifying pregnant members who smoke and recommended smoking cessation programs to these members;
 - Educating members and providers through newsletters and the website;
 - Utilizing member newsletter for smoking cessation education, utilizing provider newsletter and website to educate providers about smoking cessation;
 - Providing nicotine replacement products with a prescription; and
 - Offering smoking cessation counseling as a covered benefit.

The health plan will continue to monitor the CAHPS survey for improvements as a result of this initiative.

E. The HealthChoices MCOs Invest Heavily in Quality Monitoring and Improvement

The HealthChoices MCOs have made significant investments in their quality programs, both to implement them and to track the results such that are occurring. The programs described above require considerable staff time and expertise, as well as coordination throughout each of the health plans. For example, many of the quality improvement initiatives incorporate the use of member educational materials, outreach staff, and disease management programs. To facilitate this coordination, the MCOs have quality committees, focused on pediatric care, women's health, diabetes, asthma, and HIV. These committees work to coordinate quality related efforts across the health plan, including DM programs, HEDIS studies, other quality studies, member and provider newsletters, and NCQA activities. These committees consist of a multidisciplinary group of practitioners and interdepartmental health plan representatives. One health plan reports having 75 to 100 providers actively participating in one of the committees at any one time. The role of the committees is typically to define and evaluate parameters for utilization of health care resources, new technology assessment, quality measurement and improvement, and appropriateness and cost effectiveness of health care provided to members.

- A diabetes workgroup focuses on paying physicians to do a lab test for HbA1c in office instead of sending it out to the lab, resulting in an **increased number of people getting the HbA1c test**.
- A workgroup of neonatologists is focusing on developing NICU discharge criteria and transfer criteria. Prior to this workgroup, neonatologists did not have a forum for communication. As a result of the formation of this group, **NICU length of stay has decreased**. The workgroup plans to focus on treatment protocol for addicted neonates in the future.
- Another workgroup focusing on pregnant women with drug addictions brings together behavioral health providers, obstetricians, neonatologists, Department of Health staff, and representatives from the methadone clinics to develop treatment models for facilities to treat this population.

In addition to coordinating within an MCO, the Health Choices MCOs are able to come together to improve quality on a state-wide basis. One example is the development of the HealthChoices Adult HIV Clinical Practice Guideline. The guideline was developed to help practitioners care for adult medical assistance recipients with HIV/AIDS enrolled in the HealthChoices program. The guideline was formed through a collaborative effort among all of the HealthChoices MCOs, HIV experts, community providers, behavioral health experts, and patient advocacy representatives. The desired outcomes of this effort are to improve the quality of HIV/AIDS care delivered to adult medical assistance recipients in Pennsylvania and to reduce the variability of care delivered to this population.

In addition to the quality-related committees and coordination across MCOs, each of the MCOs makes a serious investment in monitoring the results of their quality improvement initiatives. The objective is to identify initiatives that are having the most beneficial impacts, so that these approaches can be continued and/or expanded, as well as to limit resource commitments to programs that are not producing desired improvements. This zest for continual and intensive self-evaluation was a common theme across the seven MCOs. The MCOs strive to provide high quality care for their members, and their enthusiasm about self-evaluation extends far beyond the DPW required quality initiatives and data reporting requirements. Examples of these tracking efforts is evident in the results described throughout this document. Some examples of the MCOs' investments in "self-evaluation" are outlined below.

- Several of the health plans use "secret shopper" calls to ensure that physicians are meeting access and appointment time requirements and are providing the required level of service for after-hours calls.
- One health plan has contracted with an external vendor to survey callers to the customer service hotline to assess their satisfaction with quality of service and the information provided.
- Another health plan conducts regular focus groups, as many as 12 per year, of stakeholders, including members, community organizations, and providers, to understand member satisfaction.

The MCOs produce annual evaluations to measure the effectiveness of their disease management programs, including concrete plans for future improvement.

F. Concluding Remarks

At the outset of this study, several of the HealthChoices MCOs suggested that we incorporate comparisons of HealthChoices quality outcomes with FFS quality results as a component of the quality assessment. Therein lies the crux of a key problem with the FFS model. While HealthChoices is a *system* of care that was designed to incorporate strong quality management and improvement strategies, and which lends itself to quality measurement, the traditional FFS model was neither designed nor is it a system. Quality measurement in the FFS setting is exceedingly difficult; if quality cannot be measured well, improving it is that much more challenging.

In the HealthChoices program, the MCOs have significant experience in monitoring and improving quality for their members. DPW plays a strong role in requiring a broad array of quality assurance and quality improvement components of all the HealthChoices MCOs. In addition to the required monitoring, the MCOs and their staff have a strong commitment to quality care, quality service, to monitoring themselves, and planning improvement initiatives, across every aspect of their business.

Having met with the plan staff and reviewed their programs and materials, it is by no means surprising that each entity has achieved NCQA accreditation. The breadth of the HealthChoices quality improvement and measurement activities appears to be "Medicaid at its best."

V. SPECIAL NEEDS ASSESSMENT

A. Introduction

Many states have opted to cover individuals with special health care needs, including adults and children receiving Supplemental Security Income (SSI), with complex physical health care needs, and/or with behavioral health needs, in their FFS Medicaid programs rather than including them in their capitated managed care programs. This has stemmed in large part from a concern, expressed by many policymakers and advocates, with the MCO model's ability to appropriately serve this vulnerable population.

One early concern was that traditional MCOs lacked sufficient experience serving the Medicaid population, especially those with high or complex medical needs. Some feared that the move to an MCO model would upset patient-provider relationships, which in turn would jeopardize patient health. Proponents of maintaining the FFS model for individuals with special health care needs believed that the FFS setting would better ensure access to needed services and providers. Another concern was that the capitated financing mechanism would create incentives to limit or restrict care. The advocacy community has argued that special needs populations are particularly vulnerable to bearing the brunt of cost containment approaches through reduced access to care and diminished health status.

However, there are numerous compelling arguments as to why the capitated managed care model is a particularly good fit for special needs populations. First, a large proportion of special needs individuals are in the SSI category of assistance, and the SSI population is much more stable than TANF with regard to Medicaid eligibility. This makes it far more worthwhile to implement interventions that have a long-term payoff in terms of improved health status and quality of life – such as proactively conducting a comprehensive health needs assessment at the point of enrollment and developing individualized treatment and care coordination plans.

Second, this population is beset with chronic conditions more conducive to managed care savings than is the case with TANF. Disabling physical and mental health conditions create significant savings opportunities through providing needed services in the lowest-cost setting, through slowing, halting, or perhaps even reversing progression of chronic conditions, and through avoiding clinical “flare-ups” that lead to hospitalization and other costly treatments.

Finally, the SSI and other special needs populations simply involve the most money. Per capita costs are much higher for the Medicaid blind and disabled population than for the TANF/TANF-related populations. The higher the per capita costs, the greater the opportunity for savings will be.

There is also compelling evidence that supports these arguments. As described in Lewin's Access Assessment mentioned above, the FFS model in reality does little to facilitate access to services for the Medicaid population, including those with special health care needs. One study of Medicaid managed care for children with special health care needs concluded that the FFS

model lacked the structure and support needed to service the medical, social, and mental health needs of these children and their families.¹⁹

The Medicaid FFS model in serving children with special health care needs:

- Has limited capacity to systematically identify children with special health needs and few systems for assisting them or their families in finding or choosing providers;
- Provides no guarantee of a medical home or routine preventive screening;
- Cannot assure access to the range of specialists and therapies needed;
- Has no explicit case management system that enables comprehensive assessments of children's needs, the development of a plan of care, or coordination of services; and
- Possesses little or no capacity to assist families with linking among the various health, mental health, educational, and other systems they need or the communication flow among them.

Source: Health Systems Research, Inc., *Achieving service integration for children with special health care needs: an assessment of alternative Medicaid managed care models, prepared for the Health Resources and Services Administration, July 1999.*

Research also has demonstrated numerous instances in which care for children with special health care needs is improved in the MCO model.²⁰ For example, one study found that children with special health care needs enrolled in a capitated managed care plan were more likely to receive dental care, durable medical equipment, and prescription drugs than those in the FFS model. The same study also found that children enrolled in the MCO model had lower levels of unmet need and experienced fewer problems with provider appointment and in-office wait times, getting telephonic advice, and seeing a specialist if needed. While the MCO model included in this study was a health plan designed to service individuals with special needs only, the

authors attributed the improved access and quality found in this model to features present in many capitated Medicaid managed care plans:

"We conclude that a combination of factors that characterize the capitated managed care plan are responsible for improving access to care and mitigating the level of unmet need among children with SHCN [special health care needs]. These include the comprehensive care plan assessment, ongoing case management, primary care providers' gatekeeping role, and higher physician reimbursement."

In the remainder of this chapter, we discuss the key program components that are necessary to effectively serve special needs populations, and the degree to which each of these components exists in the Pennsylvania Medical Assistance program's various settings (HealthChoices, FFS and ACCESS Plus). Section B discusses the different models' activities geared toward identifying individuals with special needs and what their needs are. Section C describes the care coordination and case management approaches used to address both the health and social issues and needs of these individuals, including the development and implementation of individualized care plans. Section D discusses the disease management initiatives undertaken to provide a system of coordinated health care interventions and communications for population subsets with specific chronic conditions.

¹⁹ Health Systems Research, Inc., *Achieving service integration for children with special health care needs: an assessment of alternative Medicaid managed care models, prepared for the Health Resources and Services Administration, July 1999.*

²⁰ Mitchell, J., Gaskin, D., *Do children receiving supplemental security income who are enrolled in Medicaid fare better under a fee-for-service or comprehensive capitation model?* Pediatrics, July 2004.

B. Identification of Individuals With Special Needs

Identifying individuals with special needs is the first step in assuring that they are served effectively. Below we provide a description of identification strategies taken or planned in the FFS and HealthChoices settings.

1. Fee-for-Service Program

Pennsylvania's unmanaged FFS setting, like most FFS Medicaid programs, does not incorporate mechanisms for identifying individuals with special needs. However, with the implementation of ACCESS Plus, the state's vendor will be required to develop and implement policies and procedures for the identification of enrollees with special needs. For instance, the contractor will be required to use claims data, as well as information collected through the state's Enrollment Assistance Program (EAP) contractor or obtained directly from enrollees and providers, to identify individuals with special needs who would benefit from case management.

The ACCESS Plus contractor must also develop and implement identification processes within its Disease Management program. These processes must include analyses of claims data to be provided by DPW and acceptance of referrals of enrollees from providers, the EAP Contractor, DPW, health plans, and enrollees who self-identify as having one or more of the selected diseases. (The selected diseases are asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease, and congestive heart failure.)

It should be noted that identification of individuals meeting specific disease-state criteria is a primary objective and strength of disease management (DM) vendors, including the ACCESS Plus DM contractor (McKesson Health Solutions). DM vendors have developed sophisticated claims coding nets and risk stratification algorithms. Where DM vendors have perhaps had less experience is in identifying individuals with multiple and complex needs that are not associated with a particular disease. Traditional PCCM vendors such as Automated Health Systems (which, together with McKesson will serve as the ACCESS Plus contractor) also have little experience in such identification, as heretofore this has not generally been a common component of PCCM programs. It is not clear whether ACCESS Plus will be able to develop and implement effective processes for identifying individuals with a range of special needs, including those unrelated to specific diseases. ACCESS Plus will face a learning curve and will have a significantly less integrated infrastructure to promote ongoing identification of special needs individuals.

2. HealthChoices Program

The HealthChoices MCOs utilize multiple approaches for identifying individuals with special needs and the nature of their needs. In addition to disease-specific claims coding nets and stratification algorithms they and/or their various disease management vendors use, the MCOs employ a number of other mechanisms to identify, at time of initial enrollment and on an ongoing basis throughout the member's enrollment, special needs that must be addressed in order to effectively serve them. For instance:

- **MCOs perform initial health assessments.** HealthChoices MCOs are required to conduct outreach to the SSI population, members with HIV, and pregnant members.

Some MCOs have developed assessment tools and conduct initial or preliminary health assessments of all members to identify any special health care needs and to provide any needed provider referrals or referrals to other services that are available through the MCO such as disease management or care coordination. MCOs do much more than simply assess health during the assessments. The initial assessments reflect the MCOs' philosophy and commitment to addressing the broader psychosocial needs of members affecting their health, and often include questions regarding concerns with domestic violence, economic factors, and overall mood and sense of well-being. One MCO conducts health assessments for entire families, if just one member of the family is determined to have a special health care need. Another MCO develops "member profiles" to understand members' specific needs. After these initial assessments, members are also "flagged" for ongoing follow-up.

- **MCOs have multiple referral sources, both internal and external, that help them identify members with special needs.** As is intended under the ACCESS Plus program, a key method by which members with special needs are identified in the HealthChoices program is via member self-referral and referral from providers. In addition, however, the integrated infrastructure of the MCOs result in additional means of identification. For instance, utilization management nurses, pharmacy technicians, and member services representatives often become aware of a member's special needs during member contact and/or standard utilization review. One MCO contracts with an outside vendor to assist in identifying and locating members with special needs.
- **MCOs operate integrated data systems that enable staff to obtain a broad overview of members' needs.** One MCO described the benefits of a system that allows appropriate health plan staff to be able to view all information on a member during a telephone contact, for instance. Being able to view member services contacts and reasons for contacts, pharmacy and all other claims, ER visits and hospitalization information, etc., helps to provide a full picture of the member's special needs. This MCO also indicated that their DM vendor also has access to the same system, allowing the vendor to note special needs unrelated to the member's disease state.
- **MCOs perform a variety of data analyses to identify members with special needs.** The HealthChoices MCOs regularly analyze pharmacy data, other claims data, hospital admission reports, member hotline call data, and other information to assist them in identifying and coordinating care for members with special needs.

"A 28 year old female was identified for diabetic case management via a routine claims activity report listing multiple emergency room visits for high blood sugars."

"The asthma case manager identified a 50-year-old male for case management from a hospital admission report."

- excerpted from a HealthChoices MCO's case reports

C. Care Coordination and Case Management

Individuals with special health care needs often require multiple health and social services from several different providers. The challenges of navigating multiple and often disparate systems of care are exacerbated by the member's condition and limited resources, leading to fragmented

care. Case management helps individuals with special health care needs by providing linkages to community-based social services, coordinating medical and social service delivery, coordinating transportation for the member to and from medical appointments, arranging for home delivered meals, and providing other similar services. The overriding goal of care coordination and case management is to marshal the medical and community resources needed to help members with special needs achieve the highest functional status possible, keep them in their homes, and improve their quality of life.

This section describes the care coordination/case management aspects of the FFS and HealthChoices programs.

1. Fee-for-Service Program

The Medicaid FFS model generally does not strive to coordinate medical care and social services for individuals with special health care needs. While the Pennsylvania Medical Assistance Consumer Handbook describes four programs that are “designed to manage and coordinate” health care services, the programs are focused exclusively on obtaining medical care services and do not appear to provide much by way of service coordination.²¹ The programs described include the following:

- The Family Care Network allows Medical Assistance enrollees aged 21 and younger to choose a family doctor, medical clinic, or health center to provide primary health care and make referrals to other providers when needed. Note that with the implementation of ACCESS Plus, FCN enrollees have been transitioned into this new enhanced primary care case management program.
- The Medical Assistance Program Exception allows members and their provider to request non-covered services.
- Prior authorization for certain covered services and items.
- The Recipient Restriction (“Lock-In”) Program to identify excessive or unnecessary treatment users, who are subsequently restricted to obtaining services from a single provider.

DPW’s Bureau of Fee-for-Service Programs does administer several special needs programs, including the Michael Dallas Model Waiver, AIDS Waiver, and Targeted Case Management, but does not appear to play a hands-on role in care coordination. In fact, the “HealthChoices Physical Health Update, July 2003” lists special needs case management as a value-added support service provided by HealthChoices but not offered in the traditional MA FFS Delivery System.²²

The ACCESS Plus program has been designed to enhance the traditional PCCM model, in which primary care providers (PCPs) are responsible for coordinating and monitoring all

²¹ Commonwealth of Pennsylvania, Department of Public Welfare, Office of Medical Assistance Programs, Fee-for-Service Consumer Handbook, <http://www.dpw.state.pa.us/omap/recinf/ffsch/omapffsch.asp#specialservices>.

²² Available at www.dpw.state.pa.us/omap/hcmc/HCPHUpdate703.pdf.

primary care and other medical and rehabilitation services for enrollees,²³ by building in HMO-like care coordination programs. In doing so, DPW truly is a leader among state Medicaid agencies in addressing some of the drawbacks of first-generation PCCM programs. That is, while PCPs may be well-positioned to manage health care, it has been noted that they may not be able to fully meet the needs of enrollees with special health care needs, particularly if their needs are extremely complex.²⁴ Furthermore, PCPs may not have the knowledge or resources to sufficiently manage or coordinate care, given the highly demanding nature of their responsibilities.²⁵

Thus, in designing the ACCESS Plus program, DPW has adopted many of the proven care coordination structures and techniques required of and employed by the HealthChoices MCOs. In fact, the February 26, 2004 minutes of DPW's Office of Medical Assistance Programs' Medical Assistance Advisory Committee²⁶ state the following with respect to DPW's managed fee-for-service strategic plan:

"The goals of this plan include improving quality and access in management of care to FFS eligibles and containing cost growth. With the delay in expansion of the HealthChoices Program, the FFS population must be looked at and the level of care improved."

Specifically, requirements outlined in DPW's solicitation of an ACCESS Plus vendor describe the extensive reach of care coordination services envisioned for the program by listing the services across which, and the special needs populations for whom, care must be coordinated:

- The ACCESS Plus vendor must coordinate care across covered services, disease management services, non-Medical Assistance services provided by community resources and Commonwealth initiatives and services such as: EPSDT screens; early interventions services; waiver services; behavioral health services; children and youth services; and Area Agency on Aging screening services.
- The vendor must coordinate care for individuals residing in various settings including private intermediate care facilities for the mentally retarded/other related conditions; residential treatment facilities, psychiatric facilities, juvenile detention centers, children in substitute care placement, transitional care homes, and medical foster homes.

The ACCESS Plus vendor solicitation also describes the specific functions of the care manager:

- Facilitating communication and coordinating service delivery between primary, specialty, ancillary, and behavioral services;
- Arranging for and ensuring coordination with other health, education, and human service systems;

²³ Commonwealth of Pennsylvania, Department of Public Welfare, RFP No. 24-04 – Enhanced Primary Care Case Management and Disease Management Services.

²⁴ Kastner, T., Managed Care and Children with Special Health Care Needs, Pediatrics, December 2004.

²⁵ Connecticut Health Policy Project, Primary Care Case Management: An Alternative For Medicaid in Connecticut, www.cthealthpolicy.org.

²⁶ Available at www.dpw.state.pa.us/omap/geninf/maac/omap022604minutes/asp.

- Working with disease management case managers and the FFS case management unit;
- Assisting enrollees with primary insurance billing and third party liability issues;
- Assisting enrollees who are deaf or who have limited English proficiency in obtaining interpreters and other needs;
- Arranging needed transportation services through MATP; and
- Attending specified DPW sponsored and community sponsored meetings, workgroups, and trainings.

The contractor also is required to develop policies and procedures to coordinate with behavioral health care and nursing facility care needs assessments.

The vendor must conduct outreach to enrollees with special health care needs, assure that enrollee needs are adequately addressed, and refer enrollees to care managers, disease management care managers, or the DPW FFS case management unit. Outreach and education programs targeting enrollees with special health care needs also must be implemented.

2. HealthChoices Program

HealthChoices MCO care coordination programs are multifaceted, serving members with a wide range of care needs and coordinating services and care across multiple providers. Below we describe case management staffing and levels of care coordination common within the MCOs, as well as discuss the models and components of case management prevalent within the HealthChoices program. Throughout, we provide case examples to vividly illustrate the value of these services.

a. MCOs have invested heavily in case management infrastructure/staffing

The HealthChoices MCOs have established infrastructures and dedicated substantial resources to coordinate care for members with special health care needs. For example, all MCOs operate a special needs unit (SNU) as required by DPW, which coordinates care between primary and specialty services, health education, and other human service systems needed by the member. SNUs also are required to assist members with special health care needs in accessing a range of services and information, including:

- PCPs, dentists, and specialists trained in the special needs area of the member;
- All covered services, including pharmaceuticals, home health, and durable medical equipment;
- Home- and community-based waivers
- Sign language services;
- Behavioral health care; and
- Other needed community services.

All MCO SNUs have a dedicated, full-time coordinator to manage and supervise staff and unit operations, and many provide care coordination services to members with special health care

needs directly through their SNU. At least one MCO had a such a unit in place several years prior to the HealthChoices implementation.

In addition to the SNU, HealthChoices MCOs have made substantial investments in care coordination activities outside of the SNU in separate care coordination units. When care coordination is provided outside the SNU, care coordinators work in close consultation with SNU staff, as well as disease management staff. MCOs' investment in care coordination is demonstrated in their staffing and infrastructure:

- **MCOs have committed staff and resources for care coordination.** Whether care coordinators are housed within the SNU or in a separate case management/care coordination unit, staffing for this function is significant. One MCO has a staff of 38 case managers, including 12 who focus on 5,000 members with multiple comorbidities and/or social issues who have been identified for intensive case management. Another plan houses 6 case managers in the SNU, all of whom are generalists but each with a special expertise/focus, e.g., children and youth on probation, developmental disabilities, complex pediatrics, behavioral health, HIV/AIDS, specialty geriatric work. In addition to these case managers, the MCO has a 14-member intake department where staff focus on short-term problem-solving. Case manager caseloads tend to vary from about 60 to 200, depending upon level of case management intensity required. Organization of care coordination staff varies; in some MCOs care coordinators serve all members regardless of their particular medical condition or specific needs, while in other MCOs care managers specialize to assist specific populations, e.g., pediatrics, NICU, adults, transplant patients, or members with very complex medical and/or social needs.
- **MCOs involve specialists and PCPs in care management.** In some cases, it may be more appropriate for a member to use a specialist as a PCP, and all the HealthChoices MCOs will credential specialists to act as PCPs in these instances. In a similar effort to provide the most appropriate specialist care, some of the MCOs negotiate higher rates with certain non-participating specialists to ensure access for the special needs population. In addition, one MCO pays PCPs special fees to create and manage care management plans for complicated special needs members.
- **MCO care coordinators are locally based.** Each of the MCOs has care coordination staff who reside in the communities where they work. Not only do these staff have a valuable knowledge of the community and its resources, they also have a strong investment in the members of these communities.
- **MCOs have implemented tiered care coordination strategies.** The HealthChoices MCOs have developed detailed protocols for assessing members' care coordination needs and transferring case files to the most appropriate operational unit and staff for coordination. For example, some MCOs have structured their services for members with special health care needs such that members may initially receive services from a care coordinator for their short-term needs, but then are transferred to the SNU for longer term coordination and service needs. This enables MCOs to spend the extra time

needed to serve the more complex needs of members with a higher level of need in the SNU without delaying services to members.

- **MCOs internally coordinate care management efforts.** Whether care coordination is provided through the SNU or through a separate care coordination unit, care coordination efforts themselves are internally coordinated among the HealthChoices MCOs' operational units serving members with special health care needs. To that end, MCOs use sophisticated computer systems for internal coordination and communication related to care coordination for members. For example, one MCO keeps electronic case files for members with special health care needs on one network that can be accessed by all MCO staff who serve the members, including utilization management, care coordinators, drug utilization review, and the medical director. The MCOs have developed detailed tracking and monitoring systems for care management programs. Tracking includes source of referral to case management, special needs indicator, type of interventions provided, as well as log of interventions.
- **MCOs use multiple strategies to reach the member.** Care coordination occurs both telephonically and in-person, as needed, and services are provided by a mix of in-house staff and care management vendors. MCOs' care coordinators commonly interact with members by *telephone* for updates on health status and whether the member was able to obtain needed services. *On-site care coordination* occurs at locations commonly used by members for whom telephonic case management was less effective. For example, if an MCO has attempted to reach the member multiple times by phone, but has been unsuccessful, often a care manager will go the member's home. MCOs also interact with members who present in the emergency room to ensure that members understand their follow-up care instructions and to prevent repeated emergency room visits. Another way MCOs reach members is through *home visits* to assess need and obtain needed information, and to follow up with members. Other outreach strategies include tailored welcome letters and newsletter articles to raise awareness.

b. *The MCOs' model of care coordination is more than medical case management*

Care coordination programs are multifaceted, serving members with a wide range of care needs and coordinating services and care across multiple providers. HealthChoices MCO care coordinators do much more than assist members in accessing needed medical services. The HealthChoices MCOs link members to other programs and services beyond just health care. Individualized care plans, which describe the member's needs, services required, and care coordination strategies, are developed by a team of providers, MCO care management and SNU staff, and the member. The care plans are reviewed regularly for appropriateness and revised as necessary.

One HealthChoices MCO conducts intensive care management with a mobile case management team of clinical and non-clinical professionals, including nurses, social workers, and outreach representatives. The in-house case management team or a provider may request mobile team services. The mobile team calls and/or visits the member to assess their needs and collaborates with the in-house case managers to develop an individualized care plan. A member of the mobile team will contact the member every 1 to 7 days, depending on need. The MCO has charged the mobile case management with the following:

- Promoting communication among providers including PCP, pharmacies, case managers, hospital, etc.
- Engaging the member to identify and address immediate needs
- Coordinating the efforts of the mobile and in house teams
- Establishing goals and interventions for members
- Being available to member after every inpatient and emergency visit
- Linking members to community and government resources
- Addressing potential alternative levels of care and services
- Identifying and addressing barriers to treatment.

Examples of HealthChoices MCO Care Coordination Efforts

One member referred to the special needs unit case manager had a primary diagnosis of HIV, seizures, alcohol and IV drug abuse, hypertension, hepatitis C, and depression. He did not have a support system and had a history of being uncooperative with hospital and MCO staff. The member was not linked to medical care, was not taking any medications, and did not have any family or friends. The case manager visited the member during a hospitalization and discussed the many community resources and services available, including: targeted case management, Meals on Wheels, mental health services, prescriptions drugs, and regular care with a PCP. The member agreed to accept help, participate in targeted case management, and begin taking prescription medication. The medication was color coded because he was not literate, and the care manager assisted with transportation to his medical appointments. The member's health status improved, he stopped abusing drugs, and he accepted healthy meals from Meals on Wheels and the food bank. He has not had any readmissions to the hospital.

-- excerpted from a HealthChoices MCO's case reports

A case manager was working with an adult, male member who had a long history of severe asthma, behavioral health issues, and frequent emergency room visits. Over many months, the case manager made multiple phone calls to establish a relationship with the patient to resolve coordination of care issues. The case manager identified a specialist the patient felt comfortable with and the patient started keeping all of his scheduled office appointments, which increased his compliance with his treatment plans. Shortly thereafter, the member's father, who was the member's only family and support, passed away. The care manager increased her calls to encourage and assist the member through this difficult period and coordinated his transportation services for physician visits until another support system could be established. Since the member has been enrolled in the case management program, his number of emergency room visits has decreased and his physicians indicate a notable improvement in his compliance with his treatment plan.

- excerpted from a HealthChoices MCO's case reports

Care coordination and case management efforts assist members in obtaining needed medical supplies and identifying and accessing social service programs such as housing and food assistance, transportation, and child care. These efforts not only enable members to better

adhere to treatment regimens and keep appointments, they also help to improve members' sense of well-being and self-efficacy. Below we summarize some of the key aspects of case management within the HealthChoices program.

- **MCOs link members to other benefits and resources.** HealthChoices MCOs assist members in identifying and applying for other benefit programs for which they are eligible. For example, one MCO identifies individuals who have claims for dialysis and contacts the dialysis center to ensure that they member has applied for Medicare coverage. This ensures that the member has all coverage to which he or she is entitled and provides a financial benefit to the MCO because it no longer is the primary payer. Another MCO helps members with special health care needs apply for SSI benefits through the Commonwealth's Disability Advocacy Program. This gives members access to additional financial resources and the Commonwealth receives enhanced federal matching payment for these members. So far, 1,100 members have been served through this program.
- **MCOs link members to other medical and non-medical services.** HealthChoices MCOs are committed to ensuring that members receive needed services, even if those services are not provided by the MCO or are not directly medical, such as housing or transportation. Examples include assisting in finding temporary residence for members being discharged from the hospital, and who need skilled care but do not have a place to live; and assisting members who are aging out of EPSDT with completing applications for waiver programs for ongoing receipt of certain services that will no longer be covered by the MCO, and following up on the status of the application.

"A member wanted to take a vacation, but didn't know if she would be able to because she used oxygen. Her case manager contacted the member's specialist and got prescription and clinical information faxed to the member's vacation destinations. The case manager was even able to help the member extend her vacation by arranging for an additional faxed prescription."

-- excerpted from a HealthChoices MCO's case reports

"A care manager received a call from the mother of a twelve year old boy with the diagnosis of Duchenne's muscular dystrophy, asthma, scoliosis, and depression. She was asking for information on any agencies that might provide funding for an air conditioner to help with respiratory problems and comfort because the member was scheduled for a spinal fusion and would be in a body cast for several months. The case manager obtained and assisted with completing a United Way application. She also secured additional funding to supplement the United Way funding, which only covered part of the cost. The mother reported that her son received the air conditioner, had his surgery, and is recovering at home."

-- excerpted from a HealthChoices MCO's case reports

"In order to allow a one-year old baby suffering from Trisomy 21 to go home with his parents from the hospital, the case manager worked with community organizations to find the funding to rewire his home so it could support his needed ventilator and suction machine."

- excerpted from a HealthChoices MCO's case reports

"A member who is blind applied for the MCO-sponsored scholarship. Over the course of six years, the member received money for tuition, books, and a computer system. The member received an associate degree, and is currently pursuing a Bachelor's degree."

-excerpted from a HealthChoices MCO's case reports

- **MCOs target certain higher-need members for more intensive care coordination.** MCOs actively identify members who have more intense care coordination needs such as those with specific health conditions (e.g., HIV, congestive heart failure), comorbidities, behavioral health care needs, or because they have a pattern of frequent hospitalizations or emergency room use. Such members receive more frequent telephone and/or in-person contact from the MCOs' case managers. For example, MCOs have implemented intensive discharge planning for members who have been hospitalized for conditions such as cardiovascular disease. MCO care coordination staff contact the member to review the discharge plan, answer related questions, and assist the member in obtaining needed follow-up care, prescription drugs, or other supplies. Care coordinators also follow up with members to confirm that they have received the services prescribed. If members experience difficulty with any aspect of the discharge plan, the care coordinator steps in to advocate on the member's behalf.
- **MCOs implement care coordination initiatives for the most vulnerable of their members.** Another MCO has implemented a special needs dental initiative through the SNU to help coordinate dental appointments for members with special health care needs. SNUs also assist with outreach to members with mental health care needs or mental retardation, including telephone outreach, mailings, and running rosters of members in need of services. One SNU is actively involved in coordinating the care of members with mental health care needs. The SNU meets twice a month with the state's behavioral health contractor to review cases of members who have high emergency room use and to identify ways to increase their use of non-emergency mental health services.

The integrated care coordination systems the MCOs have created significantly enhance access and quality for special needs individuals, most of whom under unmanaged FFS are left on their own to navigate a disconnected array of services that in no way resembles a "system" of care. However, it should be noted that, for those individuals for whom there is a system of care under FFS, e.g., children in residential facilities, imposing a different system can be disruptive. For example, we spoke with staff at a residential care facility for children, who indicated that in many ways it was easier for the children in their facility to receive care under FFS:

"Many of our residents are non-ambulatory, and under FFS, we often had specialists who came on-site to treat them. Under the current system, it is more difficult to find providers to come on-site, and in many cases it is almost impossible to get residents out of the facility to see a provider."

Most special needs individuals do not fall into this category, though; for the large majority, introducing a coordinated system of care is an enormous improvement over what they faced under FFS. We spoke with a county-level case worker at a Children's Bureau charged with protecting children from abuse and neglect, who indicated that continuity of care is a critical advantage under Medicaid managed care.

"Under the FFS program, parents 'appointment shopped' to make appointments based on convenient timing, and children would rarely see the same doctor. Thus, they had no 'medical home' and there was never any follow-up or way to

determine if the children saw the specialists they were referred to, etc. Under managed care, it is easier for care to be coordinated and for doctors to track the general health of the children. This is particularly important for at-risk children or children with special needs. Under managed care, it is easier for children to get referred to the appropriate specialists because PCPs can better understand the child's needs if they are seeing the child on a regular or continuous basis. In addition, I have contacts at each of the three health plans serving our county, and it is easier to call for questions, obtain medical records, and find the child's PCP. Under FFS, I had no regular contact at the state and was often transferred from office to office to have questions answered – obviously a barrier for parents, as well.”

D. Disease Management

Disease management is a coordinated approach to care management for individuals with chronic illnesses to help patients comply with treatment protocols, improve patient education, and prevent avoidable exacerbations of the chronic condition, while ensuring appropriate access to services. Typically, disease management programs are targeted to specific chronic diseases such as asthma, diabetes, and congestive heart failure, in which patient self-care efforts are significant. In this section, we describe the disease management services available to Pennsylvania's Medical Assistance enrollees within each of the health services delivery models.

1. Fee-for-Service Program

MCOs have been at the forefront in developing and implementing disease management programs, although states have demonstrated growing interest in incorporating disease management programs into their FFS Medicaid programs. As of March 2004, thirty states had implemented disease management programs in their FFS Medicaid settings. Until the implementation of ACCESS Plus beginning in March 2005, Pennsylvania had not.^{27,28}

The ACCESS Plus program attempts to fill this gap by incorporating disease management programs for asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), and congestive heart failure (CHF). Disease management programs will include the following components: enrollee population identification processes; evidence-based clinical practice guidelines; collaborative practice models; enrollee self-management models; process and outcomes measurement; and routine reporting/feedback loop.

The ACCESS Plus draft agreement outlines extensive requirements and responsibilities of the DM vendor, including but not limited to the staffing of local DM case managers; development of culturally sensitive methods for conducting outreach; development of processes for collaboration and coordination of services that involve community resources, relevant state agencies, providers, and behavioral health providers; and provider outreach.²⁹

²⁷ California HealthCare Foundation, *Disease Management in Medicaid*, 2004.

²⁸ Medicaid Disease Management, CMS Snapshot of State FFS Medicaid Disease Management Programs, January 2004, http://www.dmnw.org/state_activities/.

²⁹ Available at <http://www.dpw.state.pa.us/omap/rfp/ACCESSPlus/omapACCESSPlusAttA.pdf>.

As with the design of the care coordination/case management structure within ACCESS Plus, DPW appears to be attempting to incorporate DM elements that are common within MCO programs, most particularly the integration of DM with broader case management programs and philosophies. Again, Pennsylvania is at the forefront among state Medicaid FFS programs in this regard. Our experience with other states thus far has been that DM programs are not implemented in tandem with more holistic case management programs and include fewer, if any, formal requirements for broader care coordination than are built into ACCESS Plus.

It should be noted that, with regard to the effectiveness of Medicaid FFS DM programs – relative to both quality outcomes and cost savings – the jury is still out. Results thus far have been mixed (and/or in dispute), and the impetus for DM programs within the FFS setting seems not to be evidentiary, but rather based on the *opportunity* for savings and quality enhancement. We do believe that ACCESS Plus is as well-designed as any DM/PCCM program in the nation, and certainly holds significant promise for strengthening the quality and cost-effectiveness of health care for Medicaid recipients within a FFS environment. However, the success of the program likely will not be known for several years.

2. HealthChoices Program

DPW's requirements for HealthChoices MCOs surrounding disease management programs are rather vague. While the MCOs are required to “develop mechanisms for integration of disease and health management programs that rely on prevention of complications as well as treatment of chronic conditions for members identified through clinical and financial analysis of encounter data, member demographic information, and utilization patterns for preventive, secondary, and tertiary care,” DPW has not enumerated specific disease states to be managed.³⁰

Nevertheless, each of the HealthChoices MCOs operates a number of disease management programs, either internally, through external DM vendors, or both. Below we provide information on the types of DM programs that the HealthChoices MCOs have implemented and examples of DM outcomes that have been achieved within the HealthChoices model.

a. Targeted diseases and structure of DM programs

The HealthChoices MCOs conduct disease management in the disease categories targeted in the ACCESS Plus program, as well as offer disease management for a variety of other conditions, as summarized in the table that follows.

³⁰ Model HealthChoices Physical Health Agreement between Commonwealth of Pennsylvania and MCO, Exhibit M(1) - Quality Management and Utilization Management Program Requirements.

Disease Management Program	# MCOs with	
	Internal programs	Outsourced programs*
Asthma	4	3
CHF	3	3
Diabetes	3	3
COPD		2
CAD		2
Sickle cell disease	4	
Hemophilia	3	
HIV	4	
Cystic fibrosis	1	

*For some outsourced programs, certain MCOs outsource disease management only for the highest-risk members with the given condition and manage lower-risk members internally.

Many of the HealthChoices MCOs also have additional condition-specific management programs in areas such as high-risk pregnancy and pediatric and adult transplants.

The MCOs have detailed protocols for their internal disease management programs that typically involve multiple interventions. The protocols describe the background and goals of the programs, criteria for inclusion in the program (e.g., specific diagnosis codes), risk stratification methods to identify members' level of need, services available to members, provider education programs, and outcome measurement requirements. MCOs also have specialized clinical staff trained in specific therapies and disease states to provide consultation

A 28 year old woman was identified for diabetic case management via a routine claims activity report listing multiple emergency room visits for high blood sugars. For over a year, the case manager worked closely with the PCP, specialist and member on several coordination of care issues; and provided the patient with health education teaching her how to take control of her diabetes, such as learning how to use her insulin correctly and the importance of glucose level control. The member is now being followed closely by her specialist and she is keeping her appointments, her glucose levels are controlled, and her visits to the emergency room for her diabetes have significantly decreased. The member reports that she feels much better and has an improved attitude towards life in general.

-- excerpted from a HealthChoices MCO's case reports

and assistance in care coordination efforts. Examples of specialized staff include respiratory therapists (for asthma initiatives), registered dietitians (for diabetes initiatives), as well as social workers trained in care coordination. In addition to having their own in-house staff and resources for disease management, MCOs maximize community resources by engaging community-based organizations for assistance in activities such as home visits. Such relationships not only are beneficial to the members because they provide access to needed services from local, trusted resources, but also enable MCO staff to stay current with relevant community developments.

For outsourced DM programs, identification and stratification of members is often performed by the MCOs, and a number of the MCOs also develop their own physician guidelines.

The structure of HealthChoices MCO DM initiatives appears to differ from “traditional” DM programs in one significant way. That is, there is a deliberate integration of, or overlap between, DM and care coordination/case management. The MCOs are overwhelmingly unanimous in their belief that a medical model of disease management is not enough. For the MCOs, DM programs do not *replace* the individualized case management approaches described above, but rather serve as one component of that approach. Given the populations they serve, the MCOs recognize that many members who can benefit from a disease management approach will also still have present a number of psychosocial issues, as well as comorbidities, that will require specialized care management tailored to meet each individual’s specific and special health care needs.

Thus, in general the MCOs have formal procedures for integration between external DM vendors and internal case managers; employ multidisciplinary case management staff; and emphasize the social services model in the delivery of individualized care management while employing nurses as disease managers.

“Our DM programs combine a population-based strategy that seeks to managed a member’s chronic illness through a systematic treatment approach with a proactive individualized approach for patients who require specialized attention, ongoing care and treatment. There is a focus on incorporating a member’s individual needs into the treatment regimen. The Disease Managers have access to a multidisciplinary team of special needs nurses and social workers that assist in the assessment of a member’s biopsychosocial needs and develop intervention strategies accordingly.”

The box below, which provides data on one MCO’s DM and preventive health staffing and activities, is illustrative of the strong DM infrastructures and proactive interventions the MCOs engage in.

**Preventive Health and Disease Management Activities
of One HealthChoices MCO,
2003**

Staff:

- Nine paraprofessional Outreach Representatives, one of whom is Spanish speaking (these individuals conduct state-required outreach visits, but also conduct DM outreach)
- Eleven nurses who provide care management services for high risk members with asthma, congestive heart failure or high-risk pregnancy
- Three clerks who support mailings, data management, and reminder phone calls
- One Preventive Health Specialist who coordinates all Preventive Health activities
- Two Disease Management specialists who coordinate disease management activities
- Contract with outside vendor to provide diabetes disease management

Outreach:

- 15,759 cases, 70% preventive health
- 120,109 activities or interventions
- 118,850 outbound phone calls (11% in the evening); 26,610 inbound phone calls
- Outreach case outcomes:
 - 58% met goals or member already acquired needed service
 - 21% unable to locate
 - 12% outreach efforts exhausted
 - 7% refused
 - 2% other

**Preventive Health and Disease Management Activities
of One HealthChoices MCO,
2003
(continued)**

Disease Management:

- 4,139 cases
- 131,008 activities or interventions
- 77,883 outbound phone calls; 6,213 inbound phone calls
- Disease Management case outcomes:
 - 69% completed program
 - 17% unable to locate
 - 5% refused
 - 6% other

Mailed interventions, Disease Management:

- 6,000 maternity packets to newly identified pregnant members
- 75,000 post cards emphasizing importance of early prenatal care to all women ages 18 to 40
- 6,600 asthma education packets to pediatric members with asthma (ages 2-16)
- 5,400 asthma education packets to adult members with asthma (ages 17-56)
- 6,400 flyers discussing diabetes and depression to adult members with diabetes
- 7,000 diabetes newsletters mailed four times a year to members with diabetes

Mailed interventions, Preventive Health:

- 235,329 reminder letters mailed to children due for a check-up
- 112,489 reminder letters mailed to adults due for a check-up
- 16,000 birthday cards to women age 40+ to promote breast and cervical cancer screening
- 14,000 follow-up reminder post cards to women age 40+ with no mammogram four months after birthday
- 12,700 birthday cards to women age 18 to 39 to promote cervical cancer screening
- 8,800 birthday cards to children turning one, reminder for immunizations and lead screening
- 5,700 birthday cards to children turning 16, reminder for check-ups
- 7,000 birthday cards to children turning 12, reminder for adolescent immunizations
- 45,000 adolescent newsletter to members age 11 to 19 to promote check-ups, immunizations and Chlamydia screening
- 85,000 post cards mailed to children age 3 to 20 who did not have a dental exam in the previous 6 months

While the number of members participating in HealthChoices Disease Management varies according to membership size and number of disease management programs operated by the MCOs, for each MCO the number of members served by DM programs are in the thousands (e.g., one MCO serves approximately 28,000 members in its DM programs). Similarly, staffing varies according to MCO size and membership.

b. Examples of disease management program tracking and outcomes

The HealthChoices DM programs incorporate sophisticated reporting, tracking, and outcomes measurements components. Typically, outcome measures tracked include both cost indicators and quality indicators. For example, one MCO has set forth the following outcome measures for its CHF disease management program:

Cost Indicators	Quality Indicators
<ul style="list-style-type: none"> • Total per member per month costs • Inpatient per member per month costs • ER visit rate • Hospital admission rate • Hospital days rate • Physician visits • Pharmacy costs 	<ul style="list-style-type: none"> • Use of ACE Inhibitors/ARBs • Use of Beta-Blockers • Use of Aldactone • Echocardiogram performed once a year • Decrease in ER utilization • Decrease in hospitalization • Frequency of tests and distribution of values for total cholesterol, LDL, HDL, triglycerides • Percent of members with at least one LDL cholesterol test in the last year • Percent of members with most recent LDL cholesterol < 130 • Influenza immunization: percent of eligible members who receive an immunization or refused immunization during the recommended calendar period • Blood pressure: range of values for most recent systolic and diastolic blood pressure reading, and percent of members with most recent blood pressure < 140/90 • Smoking status: percent of members whose smoking status was ascertained and documented annually, and percent of smokers who were recommended or offered an intervention for smoking cessation

The MCOs also share data on these measures with their PCPs. For example, one MCO produces patient profiles for members participating in disease management programs such as asthma and diabetes. The profiles are tools for tracking patient visits and prescriptions. The MCO sends these member “report cards” to the PCP to engage the physician in the management of the patient. For instance, PCPs receive report cards on asthma patients who have been taking too many “rescue medications,” suggesting that the patient may not be compliant with “controller medication” regimens and/or other aspects of the treatment plan and requires further education.

The MCOs generally produce DM program monthly “Clinical Flash” reports, quarterly outcomes reports and/or annual evaluations in order to measure the success of the program initiatives and to revise, strengthen, and add to program components as may be suggested by program results.

Below are just a few examples of some of the positive impacts the HealthChoices DM programs have had:

- The “HealthChoices Physical Health Update, July 2003” reported that for 2002, the HealthChoices plans exceeded the Healthy People 2010 goal of 50 percent of hypertensive patients successfully controlling their blood pressure.³¹ The update also reported that HealthChoices members are getting their cholesterol levels checked at an increasing frequency and keeping their “bad” cholesterol levels at healthy levels. The MCOs’ DM programs undoubtedly contributed to these positive results. The report also attributed the following improved health outcomes to the HealthChoices asthma, diabetes, and prenatal DM and case management programs:

³¹ Available at www.dpw.state.pa.us/omap/hcmc/HCPHUpdate703.pdf.

“More than 27,000 consumers enrolled in asthma disease management programs are receiving better care for their disease as evidence by less visits to the emergency room and an increase in the number of consumers being treated with appropriate medications.”

“More than 30,000 consumers received increased care, education, and monitoring of their disease while enrolled in the diabetes disease management programs. Overall, for 2002, comprehensive care improved significantly with the greatest increases in hemoglobin A1c blood testing, cholesterol screenings (LDL) and eye exams. Eye exams of consumers with diabetes are recommended on a regular basis to reduce the risk of blindness common to the disease. HealthChoices statistics show 53.1 percent of consumers with diabetes received an eye exam in the past year, which is a 28 percent increase in the number of eye exams since 1999 and also exceeds both the commercial and HMO national averages of 52 percent.”

“More pregnant women are starting their prenatal visits earlier and are receiving more of their expected prenatal visits. Over 17,500 pregnant women were enrolled in maternal case management programs and had their prenatal visits starting in their first trimester, or within a month and a half of joining a plan.”

- One MCO reported that its asthma disease management program resulted in a 20% decrease in asthma-related hospital admissions and an 11% decrease in emergency room visits from the baseline year. Member satisfaction with the asthma disease management program is high, with 62% of members rating the program a 4 or 5 on a 5 point scale (with 5 being the highest rating).
- One MCO's congestive heart failure program experienced a 39% and 26% decrease in admissions and emergency room visits, respectively. Sixty-seven percent of members rate the congestive heart failure disease management program a 4 or 5.
- A health plan that focused on hemophilia case management found that 38 patients were generating \$12 million in annual claims. The case management program was both popular and cost-effective. A year after its implementation, the health plan found that it now had 50 high-need patients due to high satisfaction among patients and providers, as well as word-of-mouth advertising. However, the total claims costs across this larger group were only \$8 million because per capita treatment costs were reduced by nearly 50 percent.
- Another MCO found that its return on investment for all of its disease management programs was significant. For every dollar spent on asthma disease management, \$9.30 was saved; for every dollar spent on congestive heart failure disease management, \$6.60 was saved; and for every dollar spent on high-risk pregnancy management, \$1.80 was saved.

Of course, DM programs are not always successful in achieving goals in all areas. As stated previously, the MCOs act on such findings by retooling their efforts as needed, hiring additional staff, or otherwise working to strengthen their programs.

E. Concluding Remarks

Individuals with special health care needs often require services from multiple health care providers, as well as additional social services from community-based providers. For low-income individuals with special health care needs, these needs are exacerbated by limited resources. The complexity of service systems creates additional challenges in accessing needed services in a timely manner. Special needs members tend to represent the small number of people who account for a large percent of spending. It has been demonstrated that the capitated managed care model is useful in motivating plans to go the extra mile to serve these persons. In fact, research suggests that Medicaid managed care is better in meeting the needs of individuals with special health care needs than FFS programs.

Pennsylvania's DPW has demonstrated a commitment to effectively serving Medical Assistance recipients with special needs through the design of HealthChoices – and now ACCESS Plus – requirements relative to special needs units, case management, and disease management. The HealthChoices MCOs now have several years of experience with programs designed to assist their members with special health care needs. The care coordination activities of MCOs go beyond a medical focus; they also address the psychosocial factors that can impede a member's ability to access care, adhere to treatment regimens, and maximize their overall health status. In addition to their care coordination activities, HealthChoices MCOs also provide extensive disease management services. The HealthChoices program provides disease management in the areas included in the ACCESS Plus program, but also for other chronic conditions, such as sickle cell disease and hemophilia, and condition specific management in high-risk pregnancy, pediatric, and adult transplant, which so far are not a part of ACCESS Plus. The HealthChoices MCOs tailor care coordination and disease management to members' level of need, using a range of clinical and paraprofessional staff, as well as community-based resources, to ensure that members' needs are met efficiently.

The HealthChoices MCOs have already experienced notable success in serving members with special health care needs because they have committed substantial resources, developed infrastructures, and fostered key community relationships. While care coordination and disease management services in ACCESS Plus certainly have great potential and will undoubtedly improve upon the unmanaged FFS setting, achieving the same level of success already achieved by the HealthChoices MCOs requires substantial work. Furthermore, as discussed throughout this report, the ACCESS Plus program lacks a number of key features present in the capitated model that we believe are instrumental in the HealthChoices program's accomplishments: the dollar-for-dollar risk that capitation creates, a more highly integrated system of care, a local community presence, and ongoing competition for members – and recognition – that spurs innovation.

VI. CONCLUSION

HealthChoices is a highly successful program that appears to be working remarkably well for all stakeholders and to be delivering on all fronts:

- For the state, HealthChoices has delivered massive savings, and the level of savings continues to compound upwards as the health plans hold down the rate of cost escalation. Administrative costs are consuming a low percentage of revenues, yet the health plans are providing a compelling array of educational, outreach and other tailored initiatives within their administrative budgets (in addition to providing all the “routine” functions such as claims processing and payment). HealthChoices has enabled Pennsylvania to stand apart from most other Medicaid programs in recent years and preserve the Medicaid program’s eligibility, benefits, and provider payment levels.
- Medical Assistance recipients, in turn, have benefited from HealthChoices’ financial success, as over the past several years they have not been subject to the tightening of eligibility requirements or repeated new benefit restrictions that Medicaid recipients in numerous other states have suffered. In addition, the program is far superior to traditional Fee-for-Service programs in the areas of access, quality, and focus on special needs. Further, given the weaker cost containment attributes and contractual requirements of the ACCESS Plus program, we see ACCESS Plus as being incapable of achieving the same degree of health care improvements for recipients as have been accomplished by HealthChoices.
- The HealthChoices managed care organizations themselves represent financially viable health plans that, for the most part, are entirely tailored to the Medical Assistance populations they serve. Collectively, they employ hundreds of committed staff whose interest in serving this population is genuine and strong. We were struck in our site visits not only by the level of staff commitment to performing their jobs well, but also by the amount of personal time and resources the health plans’ employees devote to help the communities and individuals the health plans serve.

In short, what the HealthChoices managed care organizations provide in the way of outreach, access facilitation, innovation, cost-effective care, and enhanced quality is quite remarkable. It is important that the added value they bring to the Medical Assistance program become better understood by the policymaking community (and perhaps even by the broader population), which often seems to hear only negative stereotypes about the HMO coverage model. For those unfamiliar with the best of what Medicaid managed care has to offer, Medicaid health plans are often viewed as “insurance companies” and little more. The information presented in this report reveals the much broader role the HealthChoices managed care organizations play and should provide convincing evidence that, in many ways, DPW and its contracting health plans have achieved an ideal public/private partnership.