

# **Pennsylvania Medical Assistance: Connections within the Commonwealth's Public Health System**

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## **Introduction**

Nationally, the Medicaid program is the underpinning of the country's health care safety net. Jointly funded by the federal and state governments and administered by individual states, it is a source of health insurance for a high proportion of the most disadvantaged and vulnerable individuals, specifically low-income children and families. It provides long-term care assistance to individuals with disabilities and/or who are elderly, fills certain gaps in the Medicare program, and pays providers for treatment that would otherwise go uncompensated. Although the original Medicaid program acted like a traditional health insurance program by paying claims to providers for services given to individual Medicaid recipients, it has since evolved to being more population-oriented – like a public health system.

In this paper, we focus on the Medicaid program in Pennsylvania, known as Medical Assistance (MA), and its role in the public health system. We begin with some background and definitions about the purposes and functions of public health as these concepts have evolved nationally over the past two decades. Next, we provide a succinct description of the Medical Assistance Program in Pennsylvania, followed by a description of how MA contributes to the public health system by assuring access to personal health care services, evaluating the accessibility and quality of personal health services, monitoring health status, and developing policies that support individual health efforts. Then, we consider some of the ways that MA could be better connected to the overall public health system.

### **Background and Definitions**

The 1988 Institute of Medicine landmark report, *The Future of Public Health* (Institute of Medicine 1988, 1), defined public health as “What we as a society do collectively to assure the conditions under which people can be healthy.” The report argued that there was an organizational mechanism for achieving population health and that public health encompassed the activities undertaken within the formal structure of government and the associated efforts of private and voluntary organizations and individuals. The 2001 Institute of Medicine report, *The Future of the Public's Health in the 21<sup>st</sup> Century*, built upon these ideas and argued that the concept of a public health system describes a network of individuals and organizations that have the potential to play critical roles in creating the conditions for the public's health.

Subsequent reports defined the concept of a public health system in greater detail. Halverson (2002, 98) defined the public health system as “The organizations and individuals who collectively share the benefits, burdens, and responsibilities for the health of a defined population or community.” The Centers for Disease Control and Prevention (CDC) (2008) has said that public health systems are the constellation of individuals and organizations in the public and private sectors that provide information and assets to promote population health, provide health care delivery, and prevent disease and injury (including health care providers, insurers, purchasers, public health agencies, community-based organizations, and entities that operate outside the traditional sphere of health care).

All of these definitions have an unstated assumption: that the various parts of the system – the individuals and organizations – are interconnected and that they communicate with and reinforce each other's functions. Assuring such interconnectedness is not necessarily straightforward or simple. In the following section of this paper, we describe features of the Pennsylvania Medical Assistance Program that clearly function to benefit the “health of a defined population.” However, we later point out that the MA program lacks an explicit mandate for connectedness with the Commonwealth's governmental public health agencies and that this omission weakens the networks that support the health of all Pennsylvanians.

## **Overview of the Medicaid Program in Pennsylvania**

The federal Medicaid Program was created by Congress in 1965, as Title XIX to the Social Security Act. Governed by federal regulations, states are required to cover a set of mandated services for specific groups of people to qualify for federal matching payments. However, states administer the program and set rules for eligibility, benefits, and provider payments. In Pennsylvania, Medicaid is called Medical Assistance or MA. The Department of Public Welfare (DPW) is responsible for its management. Within DPW, the Office of Medical Assistance Programs (OMAP) has the primary responsibility for the administration of MA. However, the Office of Mental Health and Substance Abuse (OMHSA) is primarily responsible for administration of behavioral health care.

### **Program Resources in Pennsylvania**

In FY 2009, (July 1, 2008, through June 30, 2009), the state budgeted approximately \$14.4 billion in state, federal, and other dollars to pay for MA. About 55% of the total cost of the MA program will be paid from federal funds, 35% will be drawn from the state general fund, and 10% will be paid for by other funds (including \$134.1 million from the State Tobacco Settlement Fund). After basic education, MA is the second largest spending category in Pennsylvania's general fund budget – the state allocates approximately 18% of the state general fund to the program.

### **Eligibility**

Individuals are eligible for MA if they meet all of the following eligibility requirements: 1) they fit into a specified coverage group; 2) they meet the income requirement for the specific coverage group; 3) they meet the asset requirement for the specific coverage group; 4) they are United States citizens or qualified legal aliens; and 5) they are Pennsylvania residents. There are five broad MA coverage groups in Pennsylvania (children, pregnant women, families with children, individuals with disabilities, and the elderly), and each group has its own income and asset standards. In general, an individual has to be very poor to be covered under the program. There are subcategories within the five stated categories (Costlow and Lave 2007). For example, elderly and disabled individuals (with the exception of disabled children) are eligible for MA if their income is equal to or less than 100% of the Federal

Poverty Level (FPL) and their “countable assets” are less than \$2,000. Pregnant women are eligible with family incomes up to 185% of the FPL while women with breast and/or cervical cancer are eligible with family incomes up to 250% of the FPL. Children’s Medical Assistance eligibility is dependent on age; for example, children under the age of one are eligible if their family incomes are at or below 185% of the FPL; children aged one through six are eligible if their family incomes are at or below 133% of the FPL, while children aged six through 19 are eligible if their family incomes are at or below 100% of the FPL. Children who meet the disability criteria are eligible for MA regardless of their family income or assets.

### **The Organization of Care**

Although MA was initially a fee-for service program, MA recipients in Pennsylvania could enroll *voluntarily* in managed care plans starting in 1986. The HealthChoices Program, which was implemented in 1997 by DPW, expanded managed care considerably. This program separated physical health (medical services for physical health, dental care, and pharmaceuticals) and behavioral health (mental health and substance abuse) services. Physical health was to be provided through Managed Care Organizations (MCOs) and behavioral health was to be provided through Behavioral Health Managed Care Organizations (BH-MCOs). The HealthChoices program was phased in over time.

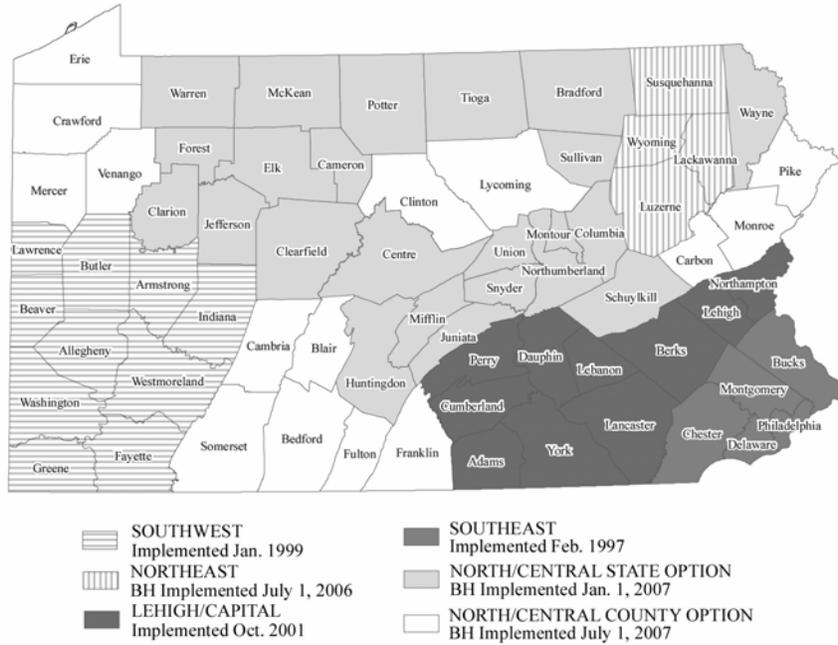
Figure 1 (page 167) shows the HealthChoices regions and the date when managed care was introduced into each region. Currently, MA recipients<sup>1</sup> who live in three regions of the state (southeast, southwest and Lehigh/Capital regions) are required to enroll in MCOs to receive their physical and dental health and pharmaceuticals. MA recipients may enroll voluntarily in MCOs in other counties (if there is a MCO available). All MA recipients receive their behavioral health care through a BH-MCO. Each county (or group of counties) contracts with a BH-MCO to provide behavioral health care services to the MA recipients in their counties. Currently, seven MCOs and five BH-MCOs operate in

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<sup>1</sup>Some groups of Medical Assistance recipients such as Medical Assistance recipients who are also on Medicare (dual eligibles), people who have been receiving long-term care for more than 30 days, children in Juvenile Detention Centers (after 35 days), and residents of a state institution are not required to enroll in an MCO. Dual eligibles were required to be in a MCO prior to 2006.

Pennsylvania. There were 1,074,230 MA recipients enrolled in MCO in December 2007. Of this number, 93.4% were enrolled in mandatory managed care.

**Figure 1: HealthChoices Regions in Pennsylvania**



In 2005, Pennsylvania launched the Access Plus Program. Access Plus is a primary care case management system and disease management system for MA recipients. The disease management aspect of Access Plus provides case-management for individuals who suffer from selected chronic illnesses. In January 2008, 293,007 MA recipients were enrolled in Access Plus. MA recipients who live in the regions where managed care is not mandated may select a primary care physician to provide standard medical care and to serve as a gatekeeper to other medical specialties.

## Managed Care and Measurement of Plan Performance

Managed care has significantly changed since it was first introduced in the 1960s and 1970s. While it began as a mechanism to contain costs through controlling the utilization of services, it has evolved into a model for improving the overall delivery of services and quality of care. When managed care was introduced into the nation's private health care plans during the 1970s and 1980s, a number of policy concerns arose. First, many policy analysts felt that the optimal way of organizing the health care system was through "managed competition." Under this system, health plans would compete for clients based on cost and quality; however, there had to be objective measures of plan quality for such competition to work. Second, employers were spending a lot of money on health care and they began to clamor for measures to assess the results of their expenditures. Thirdly, many managed care plans were paid a fixed amount per member per month, and there was some concern that health plans would limit services inappropriately. Without measures on processes and outcomes, it would not be possible to monitor health plans.

### Plan Measurement Systems

Over the years, researchers addressed these concerns, with the results that two major sets of health plan performance measures emerged: the Health Plan Effectiveness Data and Information Set (HEDIS<sup>®</sup>), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>).

The HEDIS<sup>®</sup> measures were developed by the National Committee on Quality Assurance (NCQA). These measures are derived from either administrative data collected by the health plans or from data kept by medical providers.<sup>2</sup> NCQA specifies how each measure is to be collected and measured. HEDIS<sup>®</sup> measures are frequently classified into two groups: *Effectiveness Measures* and *Access and Visits Measures*.

*Effectiveness Measures* focus on aspects of performance such as the extent to which plan members receive certain types of recommended care (i.e., screening and prenatal care) or the extent to which selected

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<sup>2</sup>For example, data on the number of physician visits can be obtained from the claims data (administrative data). However, the claims data does not have information on outcomes, such as the percentage of people with hypertension who have their hypertension under control. Thus, the health plans have to collect data from the providers' medical records to measure performance on these variables.

problems (i.e., blood pressure) are under control. *Access and Visits Measures* indicate the extent to which members make certain types of visits (such as “early care for pregnant women” and “well-child visits in the first 15 months of life”). While these measures were originally created for health plans that covered employed workers, they have been adapted for the Medicaid population. Although most of the HEDIS<sup>®</sup> measures relate to physical health care, some of them relate to behavioral healthcare.

For the CAHPS<sup>®</sup> measures, developed by the federal Agency for Healthcare Research and Quality (AHRQ), data are obtained from surveys of plan members. CAHPS<sup>®</sup> measures are frequently classified into two groups: *Experience Measures* and *Access Measures*. *Experience Measures* gauge the extent to which members are satisfied with aspects of the health plan. *Access Measures* indicate the extent to which members perceive they are able to access the services they need.

As work on measurement evolved and as health care costs continued to increase, a growing number of employers, health plans, and government programs began to look for ways to link their health care spending to quality care. This movement has been labeled Pay for Performance or P4P. By 2008, it had become quite widespread. The federal government had implemented a number of P4P demonstrations. A recent study found that more than half of a representative sample of commercial health maintenance organizations had incorporated pay-for-performance in their contracts (Rosenthal et al. 2006). A 2007 survey of State Medicaid Programs found that 43 states had implemented one or more pay-for-performance programs (Kuhmerker and Hartman 2007).

### **Performance Measurement in Pennsylvania**

Managed Care Organizations. When the HealthChoices Program was introduced in Pennsylvania, the Pennsylvania DPW mandated that MCOs report many of the HEDIS<sup>®</sup> and CAHPS<sup>®</sup> performance measures that had been developed for Medicaid plans. In addition, the Office of Medical Assistance Programs (OMAP) in DPW developed another set of measures to evaluate aspects of MCOs’ performance that were omitted by the other two performance measurement systems. The Pennsylvania-specific measures include items such as the extent to which children under six have been screened for lead poisoning or received dental

sealants. OMAP publishes information on plan performance of 27 of these measures on its website (Pennsylvania Department of Public Welfare, Office of Medical Assistance Programs 2007). In 2005, OMAP took another step to promote overall improvement in MCOs' performance by introducing a pay-for-performance system. It set aside over \$19 million to pay plans that improved their performances based on a complex formula.

Table 1, below, lists the performance measures that are publicly reported as well as the set of measures used in the Pay-for-Performance program. These measures, which are a small subset of the total number of measures reported to the state, illustrate the type of data collected.

**Table 1: Publicly Reported Performance Measures and Measures Used for Pay-for-Performance: Pennsylvania, 2003-2006**

Performance Program	Measurement Category	Performance Measures
CAHPS®	Experience	Satisfaction with Plan* Satisfaction with Child's Plan* Choosing a Doctor You are Happy with* Satisfaction with Specialist*
	Access®	Seeing a Specialist* Getting an Appointment with Your Doctor or Nurse* Getting Necessary Care* Waiting for Plan Approval*

Performance Program	Measurement Category	Performance Measures
HEDIS®	Effectiveness	Cholesterol Management Screening (after CV Events)* Cholesterol Management: LDL control <100# Controlling High Blood Pressure*# Eye Check-Ups for People with Diabetes* Diabetes: HbA1C Control# Diabetes: Cholesterol LDL Control < 100# Cervical Cancer Screening*# Breast Cancer Screening# Use of Appropriate Medications for People with Asthma#
	Access and Visits	Early Care for Pregnant Women*# Regular Prenatal Care* Regular Check-Ups for Children 3-6 Months* Well-Child Visits in the First 15 Months of Life* Doctor Visits for Children 7-11 Years Old* Doctor Visits for People 45-64 Years Old* Doctor Visits for People 65 Years and Older* Adolescent Well-Child Care#
Pennsylvania-Specific Measures		Finding Cervical Cancer in Women with HIV* Blood Lead Screening for Children under 19 Months*# Blood Lead Screening: Age 3 Years# BMI screening at Regular Check Up* Satisfaction with Dental Care* Dental Sealants for Children* Regular Dental Care, Ages 3-20 Years old* Annual Dental Visits for those with Development Disabilities* Emergency Room Visits for Asthma*

Key:

\* These performance measures are posted on the DPW web site.

# These measures were included in the pay-for-performance program.

Behavioral Health Managed Care Organizations. DPW requires that the BH-MCOs report on several measures including the few HEDIS<sup>®</sup> measures that have been developed for behavioral health (such as “patients should be followed up within specified time periods within a certain number of days after they were discharged from a hospital”). DPW also has set specific goals for selected measures (such as “involuntary admissions should decrease over time” and “less than 10% of hospitalized patients should be readmitted within 30 days”). DPW’s Office of Mental Health and Substance Abuse Services (OMHSAS) reports on the performance of the BH-MCOs through its quarterly monitoring reports (Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services 2008). These reports include information on individual performance improvement projects, adult involuntary admissions, 30-day readmissions, complaints, denials, grievances, and consumer satisfaction.

Access Plus. The reporting requirements under the Access Plus Program are somewhat different. The Bureau of Fee-for-Service, within OMAP, mines its administrative database to calculate measures of clinical quality of care and medical utilization measures for this program. It models the development of these measures after the technical specifications for the HEDIS<sup>®</sup> measures (Pennsylvania Department of Public Welfare, Bureau of Fee-for-Service 2005). In addition, OMAP requires the disease management companies to report on processes of care, as well as clinical outcomes. OMAP has also introduced a pay-for-performance system for the disease management component of that system.

### **Medical Assistance and Essential Public Health Services**

The definition of what a public health system does is well-established in the concept of “Ten Essential Services” (Public Health Functions Steering Committee 1994) shown in Table 2 (page 173). A brief review of the Ten Essential Services shows that MA contributes significantly to at least four of them. In order of priority for discussion in this paper, these four essential services are: 1) assuring access to personal health care services; 2) evaluating the accessibility and quality of personal health services; 3) monitoring health status; and 4) developing policies that support individual health efforts.

**Table 2: The Ten Essential Services of Public Health**  
(Public Health Functions Steering Committee, 1993)\*

1	<b>MONITOR HEALTH STATUS TO IDENTIFY COMMUNITY HEALTH PROBLEMS</b>
2	Diagnose and investigate health problems and health hazards in the community
3	Inform, educate, and empower people about health issues
4	Mobilize community partnerships to identify and solve health problems
5	<b>DEVELOP POLICIES AND PLANS THAT SUPPORT INDIVIDUAL AND COMMUNITY HEALTH EFFORTS</b>
6	Enforce laws and regulations that protect health and ensure safety
7	<b>LINK PEOPLE TO NEEDED PERSONAL HEALTH SERVICES AND ASSURE THE PROVISION OF HEALTH CARE WHEN OTHERWISE UNAVAILABLE</b>
8	Assure a competent public health and personal health care workforce
9	<b>EVALUATE EFFECTIVENESS, ACCESSIBILITY, AND QUALITY OF PERSONAL AND POPULATIONS BASED HEALTH SERVICES</b>
10	Research for new insights and innovative solutions to health problems

\*Entries in **BOLDFACE** type are those addressed in this paper as contributed in whole or in part by the Pennsylvania Medical Assistance Program.

### **Assuring Access to Personal Health Care Services**

Essential Service #7 calls upon a public health system to “Link people to needed personal health services and assure the provision of health care when otherwise unavailable.” The availability of health services depends not only on payment for services by or on behalf of those who need them, but also on the location of services and service providers even in areas of sparse population density. MA provides a health care plan and coverage for a large proportion of the Pennsylvania population.

Enrollment. In December 2007, 1,893,949 individuals, or about 15% of the population of the Commonwealth of Pennsylvania, were covered under MA. Medical Assistance covered almost 33% of the children in Pennsylvania. In addition, MA pays for about 41% of the births in the State.<sup>3</sup> It also covered 513,946 individuals with disabilities, many of whom are individuals with severe mental illness.<sup>4</sup> On an average month, MA covers about 38,808 children with disabilities (about 10.3% of the disabled MA population) and 1,165 women with breast and/or cervical cancer.

Since eligibility for MA is tied to income, the distribution of MA recipients varies across the Pennsylvania counties depending on the general level of income in the county. Figure 2 (page 175) shows the percentage of births covered by MA in 2005 and 2006, while Figure 3 (page 176) shows the percentage of children enrolled in MA in 2006. We focus on these groups because of the importance of medical care services, particularly prenatal and preventive care services, to the birth outcomes and the development of children.

As shown in Figure 2, there is wide variation across the counties in the percentage of births that are covered by MA – the percentage ranges from 18% in Montgomery County to 64% in Philadelphia County. These data indicate the importance for rural areas and for the poor. There were 21 counties where the proportion of births paid for by MA exceeded 50%. These counties were primarily rural counties – 17 were rural counties, two (Fayette and Pike) were fringe counties of a metro area with a population of million or more, and only two counties (Erie and Philadelphia) were metropolitan counties (U.S. Department of Agriculture 2003).<sup>5</sup> Furthermore, with one exception (Pike), the median family income in each of these counties was well below the median family income for the state: In 1999, the average median family income in these counties was \$32,850 while the median family income in the state was \$40,106 (Wikipedia 2008).

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<sup>3</sup>These two percentages refer to 2006.

<sup>4</sup>We do not report the percent of people with disabilities who are covered under Medicaid because we do not know the denominator.

<sup>5</sup>All non-metropolitan counties are classified here as rural counties.

**Figure 2: Percent of County Newborns Covered by Medical Assistance: 2005-2006**

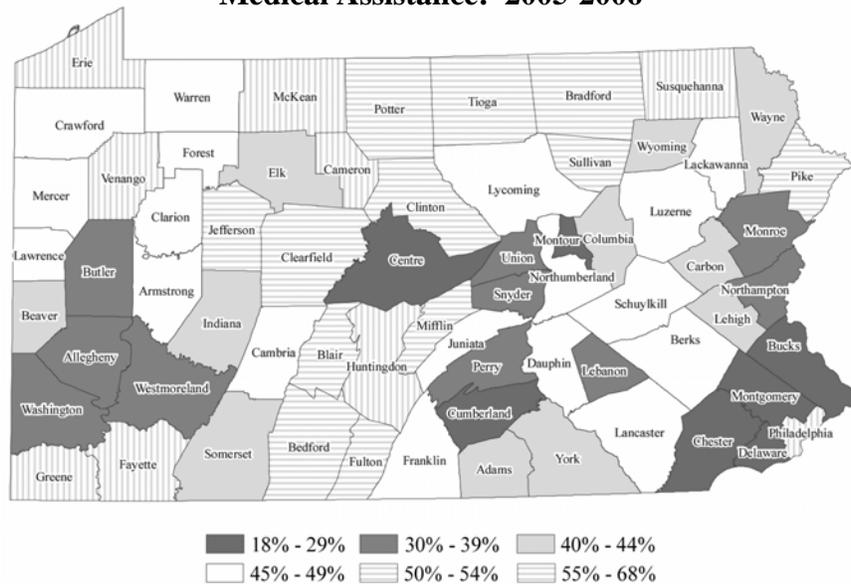
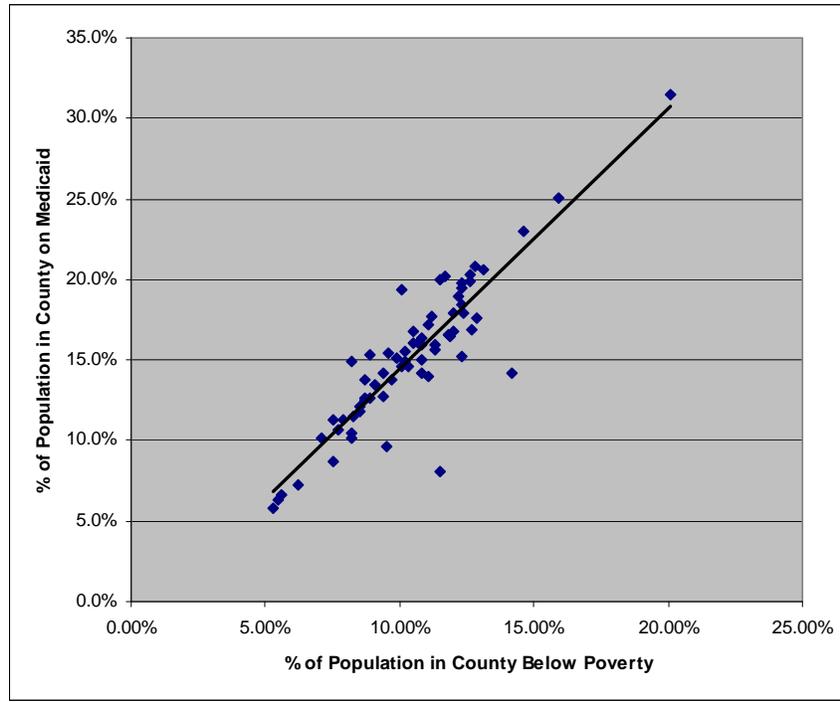


Figure 3 (next page) shows that, as with births, there is wide variation across counties in the percentage of children who are enrolled in MA. It ranges from 12% in Chester County to 63% in Philadelphia County. There are three counties where more than 50% of the children and nine counties where between 40% and 49% of the children, are enrolled in MA. Figure 4 (page 177) shows the relationship between the proportion of children covered by Medicaid in a county and the county median income. These data reinforce the importance of MA for the poor.

Provider participation. A Medical Assistance card is not of much value if individual providers do not accept MA recipients. Individual providers can choose whether to accept MA patients. Some providers in Pennsylvania, primarily dentists, do not participate in the Medical Assistance Program at all or they only accept a small number of MA patients because, they argue, the payment rates are very low. Pennsylvania Medical Assistance payment rates are in fact low. For example, the Kaiser Family Foundation reports that in 2003, physician fees under Pennsylvania’s Medicaid Program were low relative to



**Figure 4: 2006 Percentage of County Population on Medicaid by the 2003 Percentage of People in County Below the Poverty Income Level\***



\* We do not have 2006 data on the percent of the population in each county that falls below the poverty level.

**Evaluating the Accessibility and Quality of Personal Health Services**

Public Health Essential Service #9 calls for a public health system to “Evaluate effectiveness, accessibility, and quality of personal and population-based health services.” Pennsylvania’s Medical Assistance Program carries out this requirement – at least addressing the quality of *personal* health care services – by using a system of performance measures to which its MCO plan contractors are held accountable.

OMAP and OMHSA use the reported information to monitor the performance of the Medical Assistance MCOs. The general expectation is that the availability of this kind of information would help drive plan improvement. Both the MCOs and the BH-MCOs are given information on the performance of other plans as well as national benchmark information which is available for the HEDIS<sup>®</sup> and the CAHPS<sup>®</sup> data. Furthermore, much of these data are provided to other stakeholders – particularly advocates for various groups.<sup>6</sup> Furthermore, three MCOs compete for MA recipients in the three regions where managed care enrollment is mandatory. The data are meant to inform the choices of MA recipients in choosing a MCO and to spark improvements in quality. Finally, the implementation of Pay for Performance should be an additional stimulus to improvements in plan performance.

MCOs. Lave and Riaz (2008) examined the performance of Pennsylvania MCOs between 2003 and 2005. With respect to general access, they found that in 2005, the proportion of recipients who said that seeing a specialist was not a problem ranged across the plans from 58% to 74%. Furthermore, they found that the proportion of recipients who said that they could always see their doctor or nurse right away when they needed care ranged from 46% to 74%. These data indicate that there are some access problems. In looking at improvement in plan performance, they found that five of the seven plans had improved their performance on at least half of the performance measures that could be compared. However, overall performance on the CAHPS<sup>®</sup> data deteriorated over this time period. They also found that there was large variation in performance across the MCOs. The results for the Pay-for-Performance Program for 2006 also indicated variation in improvement across the plans. One plan received payouts for improvements in nine measures, one received payouts for improvements in seven measures, two received payouts for improvements in three measures, and three received payouts for improvements in only one measure (Kelly undated).

BH-MCOs. The OMHSAS Quarterly Monitoring Reports provide information on the plan performance in the southeast, southwest and Lehigh/Capital region (Department of Public Welfare, Office of Mental Health and Substance Abuse Services 2008). The data suggest that there

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<sup>6</sup>The data on outcomes for the BH-MCOs have been available to the advocates for the mentally ill.

is considerable variation in performance across the regions and within the regions across the counties. Furthermore, there were few significant trends in the data across all of the plans. General readmission rates did decrease somewhat between 2005 and 2007. The number of readmissions for the severely mentally ill (which was a focus of specific performance improvement plans) also fell.

Access Plus. OMAP has examined change over time in performance on several measures. Of the 18 measures where they could compare performance between 2005 and 2006, OMAP found that performance on 13 measures improved (four statistically significantly) and on five performance measures deteriorated (one statistically significantly). Only one formal quality report, which looks at performance in 2005, has been prepared.<sup>7</sup>

### **Monitoring Health Status**

Essential Service #1 is to “monitor health status.” This requires a public health system to collect and analyze data affecting the population’s health across several threat categories including infectious diseases, chronic diseases, injuries, and environmental hazards. Pennsylvania, like most other states, allocates responsibility for mitigating these threats across numerous state agencies; and, for the MA enrollees, several aspects of program services yield information that could fulfill the need to monitor health status.

We noted above that Pennsylvania monitors the performance of the MCOs, the performance of BH-MCOs, the performance of care managers in Access Plus for individuals who suffer from selected conditions, and the health utilization data for individuals enrolled in Access Plus. Some of these measures are indirectly related to health (such as prenatal care) whereas others are directly related to health (the extent to which blood pressure and LDL are controlled). The number of measures monitored by these various systems is very large. Furthermore, MA complies with the requirements of the federal Early, Periodic Screening, Diagnosis and Treatment Program (EPSTD), which requires

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<sup>7</sup>Access Plus – HEDIS® 2006-2007 rates were provided to the authors from the Deputy Secretary’s Office of the Bureau of Fee for Service, Pennsylvania Department of Public Welfare.

that all enrolled children are tested for specified environmental toxins such as lead exposure.

### **Developing Policies that Support Individual Health Efforts**

Essential Service #5 requires the public health system to “Develop policies that support health efforts.” At the state level, this includes health planning based on data that tracks measurable health objectives and establishes how to guide health improvement efforts. Pennsylvania has developed a number of programs within MA that support individual health efforts. One policy is pay-for-performance, which incentivizes the MCOs and the care managers in the fee-for-service sectors to exceed certain performance targets. A second policy is the implementation of smoking cessation programs for pregnant women. A third policy is the development of a set of fees that will enable the program to pay physicians for many services provided to manage the weight of their overweight patients.

### **Medical Assistance and the Pennsylvania Public Health System**

A major function of the public health system is to assure access to health care services throughout the population. The foregoing discussion demonstrates that Pennsylvania Medical Assistance or MA, functioning as a managed care program through Access Plus, carries out at least four of the Ten Essential Services of Public Health as they relate to the health care needs of the most disadvantaged and vulnerable residents in the state. MA *monitors health status* by tracking measures of performance on processes of care that are highly correlated with health outcomes (such as whether a pregnant woman had early prenatal care and whether children are receiving well-child visits) and by assessing certain types of outcomes such as whether the blood pressure of people with hypertension is controlled and whether the cholesterol levels of people who have had a cardiovascular event are within clinical guidelines. Pennsylvania MA has *developed policies and plans* to improve health care, implement a pay-for-performance system, and contract with the BH-MCOs to initiate plan improvement projects. MA *links people to needed personal health services*: it pays for about 40% of the births in the state, covers about 33% of the children in the state, and provides for the health care of individuals with physical or mental disabilities and for

the elderly. MA *evaluates effectiveness, accessibility, and quality of health services* by building and maintaining the technical capacity to assess the type of care that is being provided through the fee-for-service system and thereby assessing the managed care organizations through which it contracts.

Nevertheless, a comprehensive approach requires that we consider also those essential public health services that MA does not carry out or does not carry out alone. MA serves only a portion – albeit a large and particularly vulnerable portion – of the Commonwealth’s entire population. Although MA provides some public health services to many, the majority of Pennsylvanians are served by other health care plans or by no plans at all. If there is to be effective linkage of all Pennsylvanians to needed health care as Essential Service #7 requires, then sharing information about counties where needed services are unavailable can help other public health agencies to prioritize direct-service programs and to supplement the delivery of needed care to underserved populations. The same kind of interagency cooperation is necessary also to monitor the health of all residents (Essential Service #1), to support statewide health policy development (Essential Service #5), and to evaluate how well statewide health plans are performing (Essential Service #9).

MA’s public health services should be integrated with those provided throughout the public health system. For example, if the incidence of lead exposure detected among children in the MA program is never reported to an agency with authority to “diagnose and investigate ... health hazards in the community” (Essential Service #2), then ever more children will suffer the consequences of lead exposure. If the MA program functions only as a way to pay health care providers, then its recipient population is not benefiting from disease prevention approaches that “inform, educate, and empower people about health issues” (Essential Service #3) or that “mobilize community partnerships to identify and solve health problems” (Essential Service #4). The MA program lacks authority to enforce public health laws to protect health and safety (Essential Service #6), so its health-care contractors do not conduct the “contact-tracing” needed to prevent the spread of certain dangerous infections such as HIV. Although the MA program contributes to assuring a competent health workforce (Essential Service #8) and to

researching for new insights and solutions for health problems (Essential Service #9), those contributions are uncoordinated with other health and human service agencies in the Commonwealth.

State government holds the responsibility to coordinate among all public agencies and private organizations contributing public health services, and coordination requires communication through joint planning and data sharing. As stated by the Institute of Medicine, "States are and must be the central force in public health. They bear primary public sector responsibility for health" (1988, 143). Among the numerous public health duties of state government, those particularly important for inclusion of a Medicaid program are "assessment of health needs within the state based on statewide data collection" and "assurance of an adequate statutory base for health activities in the state" (Institute of Medicine 1988, 143).

### **Conclusions**

In Pennsylvania, the responsibility for all Ten Essential Public Health Services is distributed among several agencies of state government, local health departments, and non-governmental entities. Nevertheless, the Commonwealth retains the obligation and the powers to assure that all Ten Essential Services are being carried out and to maintain coordination and communication among the responsible agencies and organizations. The Medical Assistance Program performs some of the essential public health services, but only for its enrolled population and without formal coordination with those agencies and organizations responsible for other essential services and other population groups.

Pennsylvania's legislative policymakers should consider ways to explicitly link the public health aspects of the MA Program with the larger public health system. Two approaches to consider, both of which are currently used by other states, include:

- Making the MA Program accountable to a statewide public health policy board: Such accountability would take advantage of the excellent systems of MA quality oversight already in place and could

contribute to more robust public health programs elsewhere in state government.

- Sharing aggregated public health data: MA performance data can inform the public health system about the incidence of toxin-induced diseases in children, the sources of air-borne and water-borne toxic substances, and the geographic location of potential disease clusters. MA disease incidence data could help to inform the state's allocation of federal dollars from categorical and block grants.

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