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A core issue in policy implementation is why some policies appear to be enacted as designed while others change markedly during the implementation process. Policy implementation is evolutionary in nature and policies change. Determining how and why those changes occur can take many avenues. This case study explored how perceptions of influence held by specific groups and individuals affects the implementation of public health policy. Data were collected through structured interviews and historical document analysis. Set within the behavioral health system in Pennsylvania the study asked whether regional implementation of a new Medicaid policy – HealthChoices – was changed by the involvement of specific actors or groups. Three propositions explored relationships among and between five subsystems in the policy arena and the perceived influence of each group. The maturation of the state in policy oversight and expectation; personalities, value systems, and roles of counties in structuring the policy; and leadership changes at the state level during implementation are all referenced as reasons for policy change during implementation of HealthChoices. County government is perceived as having more influence on regional implementation. However, when not limiting responses to a particular region, the perceived influence of state and county government is almost evenly divided. The relationship between contracted managed care organization and
county government is not believed to enhance the ability of counties to influence implementation. Findings suggest the perception that the ability of counties to influence policy implementation when local government manages day-to-day operations increases. Results also appear to support that Pennsylvania is attempting to address issues of micromanagement in public policy. The research suggests new research questions in understanding the role of influence in policy implementation. These include exploration of how pre-existing relationships between state and local officials might affect the implementation process or if external factors affect the ability of actors to influence implementation.
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Chapter 1

Introduction

The implementation of public policy – turning ideas into action – has held the attention of the field for decades. A core issue in the implementation of policy remains why some policies appear to be implemented as intended by the creators of the policy while others change markedly during the implementation process. Significant study has been undertaken about the creation, implementation, and evaluation of a variety of public policies and how these activities happen in relationship to one another. There is also a wealth of research devoted to the specifics of implementing particular policies, including the influence of interest groups and government actors in all stages of policy making. This research intends to add to the implementation literature by studying how the perceived influence of specific groups and individuals may affect the implementation and, therefore, the effects of a public policy over time.

This chapter provides the contextual background for the study, specifies the problem, describes why it is worthy of exploration, and presents an overview of the methodology. It concludes by noting delimitations of the study.
Background

Through the work of scholars studying implementation, public management, interest groups, and intergovernmental relationships, public administration has sought to better define why some policies are implemented as designed and others look vastly different from their original plan. More research focus is being placed on how politics and administration intertwine – how actors and their actions contribute to the implementation of public policy (Schneider, et. al., 1997, Fossett, et. al., 1999, and Weissert, 2003). The weaving of actors into the policy process happens continuously and occurs at a multitude of levels simultaneously. Intergovernmental relationships (among and between federal, state, and local government agents) and the interactions of interest groups with governmental actors affect the implementation of policy. The question for consideration is determining if and how the perceived influence of those actors changes the implementation of a public policy.

This study addresses that question within the context of the public behavioral health care system, specifically the Medicaid program in Pennsylvania. The arena of health policy is vast and the policy community that addresses critical issues is ever changing. It is also a system with a long history of involvement from state and local government; one that has struggled with a piecemeal approach to solving social problems where focus
changes repeatedly as the issues of appropriate health care services are defined and redefined at the national level. Selecting only behavioral health issues from within the health policy arena makes the ability to examine how such policy is affected by a variety of actors (and their actions and inactions) manageable.

The delivery of public health care is always under close scrutiny. The fragmentation, duplication, and ineffectiveness in the current American system has been well documented (Judge David L. Bazelon Center for Mental Health Law, 2000). During the past 40 years numerous policies have been implemented and others abandoned in an attempt to address appropriate access to care, coverage of vulnerable populations, and control of escalating costs. In response to growing costs in Medicaid, particularly noted in the 1980s and continuing through the beginning of the 21st century, states began to seek other methods of governing public health programs that would provide needed services while controlling rising expenditures. Introducing concepts of managed care models from the private health care sector, legislation and regulation focuses on seeking more cost-efficient and timely methods of securing assistance for persons accessing public services.

Managed care models include streamlining access to treatment, continuous quality improvement, credentialing networks of providers, and controlling costs through capitation of funding. For the past two decades states have adopted these models in the implementation of their Medicaid
policies, crafting programs with similar structures and components based on federal requirement.

Pennsylvania, by virtue of its design and implementation of a managed Medicaid behavioral health program, offers a complete study context that stands alone from other issues of health policy in Medicaid. Public behavioral health services are administered apart from physical health in Pennsylvania. By separating fiscal resources and governance structure from physical health, there is greater opportunity to explore the actions and activities of defined actors.

Pennsylvania is considered “successful” in its implementation of managed public behavioral health (Johnston, 2003). The program is described as adequately funded and governed. Because of this, the state provides opportunity to explore issues of implementation beyond those often found in the literature. For example, the focus on costs, proportion of behavioral health to physical health spending, and the concerns of access in a comprehensive system have been addressed by the design of the policy. By not focusing on those issues, researchers may elect to address topics such as perceptions of influence among and between actors in the policy arena – also essential components in understanding policy implementation. By virtue of its regional implementation structure in Medicaid policy, Pennsylvania provides a research setting to explore differences within a single policy
implementation. This exploration helps understand how perceived influences of actors contribute to noticeable differences in implementation.

Although the federal Medicaid program has specific requirements, states have been able to gain exceptions to some of those requirements through the development of waivers. Many of those waivers relate to implementing managed care models. In these waivers states have taken two different approaches, seeking either a statewide implementation of managed care for all Medicaid-eligible individuals or more limited implementations that select specific geographic regions or sub-groups of the Medicaid-eligible population. Pennsylvania was the first state to implement a Medicaid managed care model with oversight of the policy delegated to county government. Other states, such as Ohio and Wisconsin, have since done the same. Though still a “new” program by virtue of its operation since 1996, the length of time Pennsylvania has been engaged in this design offers greater opportunity to explore perceptions of influences by many actors.

Exploring the ability of actors to influence the implementation of those policies provides additional information for researchers and practitioners. Health policy issues in America have been and will remain on national and state agendas for the foreseeable future. The ability of government to provide health care to populations continues to be of concern to most citizens. The development of new policies and different strategies for implementation must
account for the personalities that influence those decisions. This study contributes to that body of work.

Problem Statement

Research Question and Propositions

The study addresses how the perceived influence of particular actors and/or groups affects the implementation of public policy. Stated more specifically, the research question becomes “Is regional implementation of behavioral health policy in Pennsylvania changed by the involvement and/or influence of officials, bureaucrats, and other actors in the policy environment?” Through structured interviews with individuals involved in the Pennsylvania public behavioral health system and review of historical documents related to that system, three exploratory propositions have been established to further outline the exploration of the research question. These propositions are set forth to examine the research question and possibly generate further areas for study. The propositions are listed below.

- Perceptions of influences that affect the implementation of behavioral health in Pennsylvania are consistent across regions that
have implemented the Medicaid managed care program, HealthChoices.

- The perceived impact of influence at the county government level is greater than the impact of perceived influence of the state bureaucracy in program implementation, creating differences in the HealthChoices program across regions.

- A collaborative relationship between county government and the contracted managed care organization increases variance in implementation from the HealthChoices program as defined by the state.

**Defining Influence**

According to Dahl (1961), to define influence a researcher must consider both the specific individuals exerting pressure or leverage to drive or alter the direction of progress and the activities in which the individual engages in order to exert that pressure. He notes that it is cumbersome to describe the distribution of influence in a political system because the flow of influence is marked by strong reciprocal relationships between leader and constituents. Additionally, there are two striking characteristics of influence critical to its study: (a) the extent to which it is specialized – individuals influential in one sector tend not to be influential in others – and (b)
individuals will vary to the extent that they use their resources to exert influence (Dahl, 1982).

Influence is also defined as the ability of an individual or group to affect the course of action through specialized knowledge and/or personal relationships with key actors (Kotter, 1985). Individuals with influence are those perceived to have some ability to impact decisions or outcomes, at times beyond the formal authority of their position. This study explores what participants in a specific system believe are the influences that impact on implementation of public behavioral health policy.

**Research Setting**

The research is a single-state case study, designed as an exploratory study to further identify relationships and actions that affect the implementation of a public policy. The public behavioral health delivery system in Pennsylvania is the setting, focusing on three geographic regions that have transitioned delivery and payment of mental health and addiction services to a managed care model. This setting is well suited to the research question for a number of reasons. Foremost among these is that behavioral health services in Pennsylvania are regulated by the state and administered by individual counties or county groups. This means that while the state legislature enacts laws that govern the program, and the state’s Departments
of Public Welfare and Health administer the guiding policies and regulations, county government has some discretion in exactly how it provides services to its constituents.

The research is a limited single-state case study because Pennsylvania has not implemented the HealthChoices policy in all regions. Rather, within the state three geographic areas were selected to implement the policy on a rolling time basis; implementation was started in only one area at a time. Although the initial intent of state officials was to complete implementation throughout the commonwealth by the end of 2005, only 25 counties in three regions are currently operational (Department of Public Welfare [DPW], 2005). Managed care expansion has slowed across the country in the twenty-first century. This has been attributed to a variety of things, but most notably the economic downturn following the terror events of September 11, 2001. Pennsylvania’s slowing of managed care expansion is not an exception in the United States. Other states have done the same or even cut back on existing managed care models in an effort to contain costs.

Overview of Methodology

Comparative case study in social sciences has endured and enjoyed popularity as a way to explore relationships in complex policy arenas. It is accepted that the policy process – from design through evaluation – is messy.
Theories have been developed that provide a framework of phases and stages through which policy is implemented (Hargrove, 1980; Ingram, 1990; Rein & Rabinovitz, 1978; Williams, 1980). Case study research, by providing in-depth exploration and reporting on individual policy arenas, assists in providing background for the models and frameworks that have been developed about the policy cycle. The case study can be used to investigate a contemporary phenomenon in a real-life context, especially when the boundaries between phenomenon and context are not clearly evident (Yin, 1994). Influence in public behavioral health is a fitting topic for case study research.

Following an in-depth review of background information related to the public behavioral health system in Pennsylvania, two avenues of information sources were selected to obtain data. Primary data came from interviews with individuals directly involved in HealthChoices implementation. Secondary data came from an historical document review including information published by the state of Pennsylvania, county government and affiliated oversight companies, managed care organizations, and the mass media. Those data will (a) provide additional support or refute background information collected, (b) provide information specific to each proposition, and/or (c) assist in determining if there are other factors aside from the perceived influence of individuals or groups of actors that might affect differences noted among and between HealthChoices regions.
Rather than determining causality between the structural features of implementation models and outcomes of those models, the research sought to find and describe how relationships and the perceived influence of actors in those relationships affect change in the implementation process. An understanding of the evolution of policy implementation was the goal. As such, this research is an exploratory study. The detailed research design is found in Chapter Four.

Professional Significance of the Study

Policy Issues in Behavioral Health Care

The public behavioral health care system, with its history of governmental involvement in design and private sector involvement in delivery, provides an opportunity to examine closely how influence of a variety of actors is perceived to affect the implementation of intended policy. The public behavioral health delivery system changes dramatically in response to changes in legislation. Until the 1960s, public behavioral health meant treatment in a publicly owned and operated mental hospital or in one of the few community clinics (Frank & Morlock, 1997). Since the adoption of the federal Community Mental Health Centers Act in 1963 and the creation of the Medicaid program in 1965, public care in behavioral health has shifted
to a complex array of publicly owned providers (primarily hospitals),
contracted caregivers, and private community-based providers. This shift in
policy was designed to create an array of services that persons could access to
address their behavioral health care needs (Keisler & Sibulkin, 1987).

In the 1960s, policy makers determined that it would be more efficient
and effective for persons with mental illness to be treated in their own
communities rather than housed in institutions. The understanding of
mental illness had changed; removing individuals from their home
environments did not enhance their ability to get well as it removed them
from their natural supports. It was also very costly to maintain large public
institutions. The new policies began an implementation process that changed
not only how services were delivered in the behavioral health arena, but the
prevailing view of the value of the person with mental illness. This policy
change focused the implementation of behavioral health policy for the next
twenty years, with ever-growing support for community-based programs that
would enable persons with mental illness to live and work in their home
communities.

Until the 1980s the majority of issues arising in the behavioral health
policy arena were focused on whether a medical model or social model should
be used in the approach to treatment (Patel & Rushefsky, 1999). The medical
model is centered in the belief that mental and addictive disorders are
diseases, biologically based, that should be addressed whenever possible
through the use of medications. The more prevalent social model is centered in the belief that while mental illness and addictive disease may have a biological component, they also require attention and treatment of issues related to individuals being able to live and function successfully in their communities. Both models remain a focus of treatment providers and policy makers today. Although neither has been accepted as the only answer to the issues of mental illness and addictive disease, the policy arena has more recently begun shifting back to a medical model as evidenced in the design of managed care programs addressing treatment of symptoms and an emphasis on psychotropic pharmaceuticals to contain costs (Rich & White, 1996).

This leaning bears itself out in what is described as the most wide-reaching change to public behavioral health policy since the inception of the Community Mental Health Centers Act. By 2002 Medicaid was paying for healthcare services to more than 47 million low-income and disabled persons (Hurley & Somers, 2003). Medicaid funding supports persons with severe mental illness – those for whom mental illness prevents their ability to work or function in the usually expected manner of adult persons in the United States. Medicaid was funding nearly half of all expenditures for public sector community behavioral health care; spending reached $16.7 billion and utilized 9.5 percent of the Medicaid budget (Frank, Goldman & Hogan, 2003). In response to growing costs, governments adopted the concepts of managed care models, crafting legislation and program standards focused on seeking
more cost-efficient and quicker methods of securing assistance for persons with behavioral health issues in the public sector.

By 2003, 48 states (all except Alaska and Wyoming) had created some form of managed care policy in public behavioral health covering 58 percent of the Medicaid-eligible population (Hurley & Somers, 2003). These policies differ from state to state in how they are designed, controlled, paid for, and the breadth of the population being covered. The publicly managed health care plans are also affected by the intergovernmental relationships overseeing them, the attention and focus of the state legislature and state bureaucracy on the issues of public behavioral health, and the political climate in which they operate. For instance, in Minnesota, where Senator Paul Wellstone was a national advocate for the effective treatment of mental illness, public behavioral health programs are – in comparison to many other states – well-funded, widely available, and designed to address access and quality of care issues in equal proportions to containing costs (Beinecke & Lockhart, 1998).

The change in the focus of behavioral health over the years highlights the difficulty in states’ implementation efforts. It is not clear that the desire for both high quality and cost-effective programs can be reached concurrently. As well, how programs are conceived and the emphasis placed on their use varies based on the political landscape within which they operate. If public policy is indeed affected by the actors involved, then
sufficient recognition of that must be given to the implementation processes, allocating more resources to understanding why particular implementation models are chosen and why they operate differently.

Influence in Managed Care

Managed care models are but the newest in a long history of attempts to address competing goals of public health policy – controlling costs while still assuring access to appropriate care for vulnerable populations. As the federal government moved states toward new models of health care legislation and delivery, it became increasingly important to determine how those models are implemented and which, if any, are more likely to reach intended policy goals. By focusing on one section of public health – behavioral health – that has common identified actors, a specific federal mandate for service delivery, and addresses a smaller portion of the population in question, opportunity exists to discover information to address the unanswered questions of how the perceived influence of actors affects policy.

Managed care models continue to proliferate in public sector health services in the United States. Research and public sentiment to date indicate that the likelihood exists that they will continue for the foreseeable future as government attempts to continually address the dual needs of its citizens –
providing effective care while controlling costs (Birnbaum, 1998; Forquer & Sabin, 2002; and Hurley & Somers, 2001). By understanding one portion of managed health care and how influence is perceived to affect the design and delivery of services under the policy, opportunity exists to expand those findings to other areas of health care and social services.

Federal interest in the Medicaid program continues to grow in importance. The current Bush Administration has proposed caps on Medicaid funding for states and requested reductions in Medicaid spending in FY 2006 (FamiliesUSA, 2005). In December 2005, Congress passed a budget bill reducing Medicaid spending by almost $40 billion (National Council for Community Behavioral Healthcare, 2005). Even so, cost escalations in the Medicaid program are predicted in double digit percentages and states will be further pressed to make program changes. This exponential growth – much of which is allocated through waiver services to state Medicaid programs – continues despite targeted cuts, making it impossible for government to assure care to all currently eligible populations. The focus of the current Bush Administration is not unique; administrations for the past two decades have sought answers to the “problem” that is Medicaid (Weissert & Weissert, 2002). By increasing the research base through the study of perceived influence in the implementation of health policy, opportunity exists to expand the dialogue with persons involved in assuring the existence of a public health system.
Delimitations

Although the provision of three regions of study exists within the research design, the fact that it remains a single-state case study creates limitations. Pennsylvania is one of the largest Medicaid programs in the country, with an annual budget close to $14 billion. However, the study group in this research is only a portion of that total. While limiting the size assists in making the research manageable, it constrains the ability to generalize results to similarly structured efforts in health policy.

The dynamics of county government in Pennsylvania are different from other states. Therefore, actors perceived to influence policy in this study may differ from those in other settings. Through passage of its own law in 1966 regarding the delivery of human services (following the federal Community Mental Health Centers Act of 1963), Pennsylvania allocated responsibility for and control of human service delivery to county government. Sixty-seven counties, governed by elected commissioners or an elected county executive, are responsible to see that services are available in local communities.

Although counties must be responsive to state regulations and funding guidelines for Medicaid services, they have greater discretion in determining the use of “state only” funds for human services – those not supported by federal matching funds. This creates a shift in levels of policy control not always experienced in states with comparable human service budgets where
the state has controlled human service funding without county-level input. The experience of county officials in managing some behavioral health funding prior to beginning Medicaid managed care may affect how actors in Pennsylvania are perceived to influence behavioral health implementation.

In addition, the Medicaid managed care program in Pennsylvania (as in most states) is relatively young, with initial mandatory services beginning in the Southeast zone of the state in 1996. It has evolved slowly over the course of eight years to its current status, operational in three geographic regions. The remainder of the state (42 counties) continues to provide Medicaid in a fee-for-service environment, where providers are reimbursed directly by the state for treatment delivered.

Many actors involved in initial public managed care implementation activities remain in the current system, though several have moved to other offices or roles. The impact of that pre-existing network may impact perceptions of influence in a way not duplicated in other states where this has not happened. Nevertheless, the ability to provide more data related to the influence of interest groups and governmental actors in the implementation of health policy remains important.
Summary

This chapter provided the contextual background for the study including the specification of the problem, the research question and study propositions. It introduced the nature of the single-state case study and described why Pennsylvania is a good candidate for this research. Chapter Two delineates the knowledge base from the literature upon which the research was built. Chapter Three outlines specific background about Pennsylvania and public behavioral health. This background is necessary to provide readers with knowledge about the policy arena of the case study. Chapter Four is comprehensive in outlining the research methodology. Research findings are presented in Chapter Five, addressing each of the exploratory propositions in context of the research question. Finally, Chapter Six provides conclusions and suggestions for additional research.
Chapter 2

Literature Review

The public behavioral health system, with its history of multiple levels of government and private sector involvement in policy implementation, provides an opportunity to examine how the interactions of policy actors and the perceived influence exerted by each shape the implementation process of policy. With changes in the last decade that have moved public health policy into new structures (managed care) it also provides opportunity to explore how the implementation of public behavioral health models addresses one of the big questions in the field of public management: “How can public managers break the micromanagement cycle – an excess of procedural rules, which prevents public agencies from producing results, which leads to more procedural rules, which leads to...?” (Behn, 1995, p. 315).

In the early 1950s Anderson and Weidner discussed several social policies, including health. They noted that it was obvious that public policy in these areas is not formulated in the legislature and administered in various state and local agencies without change. Instead, they stated, “social policy is formulated by public opinion, pressure groups, legislators, and administrative agencies, among others” (Anderson & Weidner, 1951).
Health policy, and Medicaid policy in particular, has been the focus of vast amounts of research related to any number of propositions. Major research institutes (for example The Nelson A. Rockefeller Institute of Government and The Urban Institute) have devoted years to researching such issues as financing structures, managed care, and the politics of Medicaid, especially as they relate to the economic impact of the program. Medicaid has been the focus of researchers studying implementation, policy design, intergovernmental relations, and interest groups. However, until very recently the majority of those studies have concentrated on issues other than how influence shapes implementation. For example, they have attempted to measure program success, cost-containment, simplification of eligibility structures, and consumer satisfaction (Beinecke & Lockhart, 1998; Coffey, et.al., 2000; and Rowland & Tallon, 2003). While all of these are important, it is only recently that attention has been paid specifically to the pivotal role politics and influence plays in Medicaid implementation (Weissert, 2003).

This chapter provides a background of relevant literature for the proposed research. Issues of implementation, intergovernmental relations, and interest groups are all blended within the framework of Medicaid policy. The discussion concludes with a summary of how the research can provide information relevant to the big question of micromanagement posed by Behn.
Policy Implementation

Implementation models and theory have been a part of the political science literature for decades. Studying policy implementation reaches far beyond the determination of whether goals of a stated policy have been accomplished. Implementation also focuses on the strategies and tactics employed by actors in the process, decision parameters including that of delay, and the motives of the actors (Lane, 1995). Through the evolution of the study of implementation researchers have attempted to clarify how the entire public policymaking process works. They have formed assessments about causal relationships in specific studies and clarified relationships between objectives and outcomes to affirm that policy goals have been achieved (Stroul, Armstrong, & Meyers, 1998; Hurley & Somers, 2003). What was once perceived as a rather straightforward and mechanistic process of implementation has evolved into an understanding that policy implementation itself is multifaceted and adds further complexity to already broad policy decisions.

Rather than simple or straightforward, policy implementation is evolutionary. If viewed as a learning model or model of evolution, implementation becomes endless. Each step in the process results in a redetermination of outcomes, which in turn change objectives. If the objective of the policy changes then successful implementation (however
originally defined) cannot occur because the policy being implemented has not remained the same (Bardach, 1977). This scenario has certainly played itself out over the course of implementing federal and state level Medicaid policy in the last 40 years. What started during the Johnson Administration as a program to assure basic health care for the poor has turned into the largest health care funding system in the nation providing a variety of services to millions of persons. By 2002, 43 percent of federal funds delivered to the states were for Medicaid (Hurley & Somers, 2003). Behavioral health services (mental health and drug and alcohol treatment) provide a smaller and more contained context for understanding how Medicaid policy has changed during the process of implementation.

As noted in Chapter One, public behavioral health care shifted from treatment in publicly owned and operated mental hospitals to services being delivered by a complex array of public and private hospitals, contracted caregivers, and private community-based providers in the mid-1960s. The shift in policy created an array of services for persons to address behavioral health needs in their own community. It also meant a dramatic shift in implementation of services as states would now be responsible to provide treatment to their citizens in less-contained settings. These changes fundamentally altered the landscape of behavioral health policy implementation (Essock & Goldman, 1995).
Implementation plans in behavioral health had to fall under the primary responsibility of the states if services were to be delivered in the community. Given almost exclusive control to design and then implement effective systems of care by the federal government, states began to encourage and/or develop services they felt would best meet the needs of their constituents. At the same time, they had to form new relationships and new ways of doing business with a multitude of institutions and other providers. Individual states differed dramatically in their ability and willingness to respond to the change in structure. States with greater populations of persons with mental illness and addiction problems wrestled with different implementation issues than those states with fewer persons needing care, but spread out over greater geographic distances. Issues of accountability and trust had to be addressed (Sabatier & Mazmanian, 1981; Sabatier, 1986; Lane, 1995). Symptoms of control, hierarchy, and planning came head to head with the need to be adaptable during the evolution of new treatment systems.

The Evolution of Implementation Theory

In 1984 Wildavsky conceptualized a theory of a process of implementation that results in a redefinition of objectives and reinterpretation of outcomes – implementation evolution, in other words.
Implementation is endless and inevitably reformulates the initial policy. The theory also supports the idea of policy change through incrementalism. Further work discussed implementation as a learning process (Wildavsky, 1988) where implementers develop improved functions and more reliable technologies for programs through learning. Again, the evolution of Medicaid implementation demonstrates this.

As states continued in the administration of Medicaid plans over the latter half of the twentieth century and experienced varying levels of “success,” they began to make more and more changes to rules and regulations governing treatment. Across the nation additions were being made to available treatment services. No longer were there only two primary therapeutic interventions (inpatient hospitalization or outpatient counseling), but through the development of program models and advances in the clinical field options such as new medications, family treatment, and vocational rehabilitation all became a part of the behavioral health system and, as well, part of state Medicaid programs (Goggin et. al. 1997., and Goggin, 2003). State and county governments were recrafting implementation plans as more treatment models were determined effective and more actors became a part of the policy process. Elmore (1978) and Lipsky (1978) took into account how the involvement of more individuals would change implementation theory. They indicated that more attention should be focused on those responsible (bureaucrats) for day-to-day implementation of a policy. Although they
constrained their model by focusing on only one component of a very complex process, their work opened the door to further exploring the evolution of actors involved in policy implementation.

Sabatier (1986) argued that implementation processes are affected by advocacy coalitions – actors from public and private organizations who share a set of beliefs and seek to realize common goals. The idea of the advocacy coalition network – applicable to all stages in the policy making process – draws into the discussion more policy actors than previously considered. It expands the understanding of the breadth of actors involved and sets the stage for the consideration of interest groups and understanding influence in relationships in the process of policy implementation. Implementation studies began to address more of the political activities and actions that are integral to effective implementation of policy. This transformation required attention to bargaining, convincing, pushing, and pulling by specific actors. These activities are essentially political in nature and result from the interaction of different sets of actors. They bring an understanding that policy implementation is accomplished by more than those charged with specific tasks through formal bureaucratic structures. Rather, returning to the process noted by Wildavsky, evolution and learning in implementation changes the very nature of the policy and affects actors in a variety of subsystems – federal government, state government, and identified interest groups.
The Role of Interest Groups

The research in interest groups is robust, running the gamut from the identification of interests as an integral part of the policy process to determinations of what activities are undertaken by interest groups and how these activities impact all areas of the policy cycle (Barrilleaux & Miller, 1988; Schneider, 1988). Organized interests have proliferated over the past 20 years (Loomis & Cigler, 2002) and the trend toward increased representation continues. As policy arenas continue to increase in complexity more groups are identified and seek access while long-time interests look to increase the level of influence they have in the policy process (Thurber, 1991). The addition of new interest groups to a policy domain alters existing relationships between groups and government actors and may provide for new opportunities for influence (Schneider & Jacoby, 1996).

The primary target for interest groups has been the legislature. However, more recently interest groups have been indicating attempts to lobby the bureaucracy in attempts to shape influence (Nownes & Freeman, 1998). This evolution in focus appears to have occurred in concert with the growing understanding of how the act of implementation is a continual one. Rather than expending additional effort to influence new policy at the legislative level (which becomes rarer) interest groups believe they will have a greater impact working with the administration charged with enacting
policy, influencing change on smaller scales. In terms of health care, research has shown that interest group pressure has affected state Medicaid policy (Rochefort, 1997). Schneider and Jacoby (1996) note, however, that Medicaid administrators are not equally attentive or responsive to the demands of all health related organizations. Some groups have greater access and, therefore, more say.

Interest groups, regardless of policy domain, appear to engage in similar activities in an effort to exert influence in design, implementation, and change in policy (Nownes & Freeman, 1998). These activities include lobbying and providing technical information. In fact, the more technical the issue the greater the involvement of interest groups appears to be (Schneider & Jacoby, 1996). This appears to be the case in Medicaid policy as the complexity of the program has continued to increase. Weissert (2003) has noted that state legislators are not generally well informed on the workings of the Medicaid program. This provides greater opportunity for interest groups to impact state health policy.

It needs to be noted that state and local governments also operate as interest groups, lobbying each other and the federal government for changes in areas such as health care (Cammisa, 1995). In the late 1980s and early 1990s states began to increase pressure on the federal government to change the way Medicaid was structured. Federal regulations had become too cumbersome and too inefficient. “One size fits all” models were insufficient to
take into account significant differences noted in state political, geographic, and service parameters (Weissert & Weissert, 2002). Rising costs to states for health care for the poor needed to be addressed and, if possible, contained. State governments wanted to apply techniques they had learned from the private health care sector to manage treatment for the publicly served population. Over time and through a series of pilot projects, more and more states began to adopt the view that managed care techniques (controlled access for clients, capitated payments, and provider networks) were central to their ability to manage public health care and they began applying for waivers to federal regulations governing Medicaid (Rich & White, 1996). Through Medicaid waivers states sought to create models that provided flexibility to develop more cost-effective measures to address specified community needs while assuring that all desired and required populations could still be covered.

Central to most Medicaid waivers is the ability of state government to determine who can and cannot provide treatment, what services will be included, and what populations should and should not be covered. The federal government, in approving requested waivers, gave states even greater control over implementation of the Medicaid program (Centers for Medicare and Medicaid Services [CMS], 2002). States were allowed to suggest alternative models for access to care and reimbursement of services. However, in order for most states to implement the waivers they designed,
entire treatment delivery and reimbursement models would have to be restructured. No longer did states want to provide the link to direct access to services and pay individual providers for care. Instead, they strove to become mega-purchasers of treatment systems for population groups, moving day-to-day management of operations to local governments and/or managed care entities (Forquer & Sabin, 2002). Moving to these new models paved the way for more and different actors to become involved in the implementation of Medicaid policy.

In Pennsylvania the state administration chose to operate a model of Medicaid managed care in which behavioral health was carved out from physical health. Through receipt of a waiver from the federal government in 1996 (CMS, 2002) the state pursued a two-part plan; the first part addressing physical health and the second behavioral health. In other words, through a carve-out of behavioral health from physical health, discrete funds would be set aside specifically for use in behavioral health treatment. At the same time the state provided county (local) government additional options for control of the redesigned Medicaid system and its subsequent implementation. Pennsylvania offered to counties the “right of first opportunity” (Commonwealth of Pennsylvania, Department of Public Welfare, 1996). If the county or a group of counties so desired, they could be the contracted entity to assure the provision of behavioral health treatment services. Every county initially accepted the opportunity.
Most county human services in Pennsylvania, however, did not believe they were in much better position to be able to manage the delivery of treatment than the state. They, in turn, created or contracted with managed care organizations to develop comprehensive delivery models for behavioral health services in their communities. By doing so, actors and interest groups in the policy system attempted to exert influence and control in the implementation process differently, further affecting the political dynamics of health policy (Frank, Goldman, & Hogan, 2003).

**Intergovernmental Issues in Medicaid**

No discussion of the role of influence in implementation can be complete in the public sector without also considering the role of intergovernmental relationships, especially in Medicaid. Intergovernmental relationships are interdependent and complex. Power is shared among levels of government and no one consistently controls all policy decisions. As well, no one level of government can consistently possess enough information about all of the components to make rational implementation decisions on its own (O’Toole, 2000). All three levels of government (national, state, and local), private insurers, providers, and other interest groups are potent actors in the field of public behavioral health. Schenider and Jacoby (1996), Devers (1997), and WeSSERT (2003) have all noted the pivotal role that state
Medicaid agencies play in shaping and implementing Medicaid policy. This shaping comes in the form of influence – having the ability to affect the course of policy implementation – and is different dependent on the type of administrative structure operating to manage the policy implementation.

Most states have created some form of Medicaid managed care policy for public health, covering 58% of the Medicaid-eligible population (Hurley & Somers, 2003). These policies differ from state to state in how they are designed, implemented, controlled, paid for, and the breadth of the population being covered. Thirty-seven states operate some form of public/private partnership in their Medicaid managed care plan. Public managed care plans are affected by the intergovernmental relationships integral to their operation, the attention and focus of the state legislature and local governments on the issues of public behavioral health, and the political climate in which they operate.

Although Medicaid was designed by the federal government and includes mandates for service provision, most of the control for operations belongs to the states, who may further share that control with counties and/or other local governments, believing that a partnership across levels of government improves access and quality of care for vulnerable populations better than any single level of government could do on their own (Schneider, 1988; Fossett, et. al., 1999). While allowing implementation activities to be more attentive to identified needs of local communities, these same
partnerships also make it more difficult to affect change in times of economic recessions and budget cuts. The number of stakeholders involved in implementing policy has increased. Consequently, the number of stakeholders wielding some level of influence in the policy arena has also increased.

Medicaid policy changes often initially occur at the federal level as administrations change and the federal domestic agenda is altered. These changes affect the relationship between federal and state governments. For example, in the late 1990s as a Republican Congress and Democratic administration moved away from the welfare policy of Aid to Families with Dependent Children and into Temporary Assistance for Needy Families Medicaid eligibility rules changed (Ellwood, 1996; Ku & Coughlin, 1997). Federal matching funds received by states decreased as enrollment in welfare programs dropped. This in turn affected the relationship between state and local governments charged with the implementation of Medicaid programming. The opportunities for influence between governmental actors increased as changes were made in the public health arena (O’Toole, 2000). State leaders, faced with the ongoing increase in expenditures for their programs because they provided more services or benefits to larger populations than those federally mandated, had to become leaders in the shaping of health care policy at both the state and national level (Schneider, 1988; Anton, 1997). In concentrated efforts to assure that they were
receiving the optimum federal match for Medicaid, states worked to redesign Medicaid programs to shift state-only behavioral health costs into available federal matching funds programs. Doing so has more tightly linked state mental health expenditures to federal policy than at any other time in US history (Frank, Goldman, & Hogan, 2003). At the same time, transferring more responsibility from state to local government for Medicaid implementation results in the need to devise mechanisms for holding lower-level government accountable for the use of federal and state dollars. As long as this process of shared responsibility continues national, state, and county government must remain in relationship with one another (Anton, 1997).

The governmental framework in which health policy is implemented continually changes, consistent with the evolving nature of policy implementation and the changes inherent in elected administrations (Schneider, 1988). With this evolution, especially in behavioral health in states such as Pennsylvania, have come changes in the actors involved and their roles in implementation. Where influence lies in shaping implementation, whether it is shared or belongs primarily to one group, affects relationships between levels of government and how policy is managed.
A Question of Public Management

In 1995 Behn proposed three questions that he argued belong in the “top ten” of issues confronting public management. He indicated that the fundamental management dilemmas of micromanagement, motivation, and measurement deserved focus and, if they could be answered, would make a significant contribution to the ability of public managers to get their public agencies to produce results. This research study of the perceived influence of actors in the implementation of public behavioral health policy may provide insight into the first of those questions, “How can public managers break the micromanagement cycle – an excess of procedural rules, which prevents public agencies from producing results, which leads to more procedural rules, which leads to...?” (p. 315)

Behn notes that the issue of micromanagement has been long identified as a major problem in the public sector. Issues of trust, governance, and entrepreneurship all frame the ability of the field to address the question. In writing about the level of distrust between branches of government Behn notes how that distrust extends itself not only to issues between branches of government such as the legislative and executive branches, but how distrust is further delineated within public agencies. Political managers frequently distrust career employees of an agency and, in
turn, oversight agencies don’t trust line agencies to carry out policies. What results is micromanagement – procedural rules beget more procedural rules – increasing levels of distrust and preventing agencies from achieving results.

Issues of distrust and actions to increase levels of trust may be addressed within the research findings of this study. Restructuring of the Pennsylvania Medicaid program required federal, state, and county governments to interact differently with each other. How much of the activity previously controlled by state government could be devolved to counties? Would the federal government, in granting the waiver to Pennsylvania, trust that the state could provide effective oversight of counties to implement the policy?

Behn also reformulated the micromanagement question as one of governance. With decades of research refuting the politics-administration dichotomy as the obvious answer to the question of governance, issues of how policy choices are made and who makes them affects how public managers operate. In its move to managed care in Pennsylvania public behavioral health the state proposed changes to the issues of governance, designing a policy that would allow county government the ability to control day-to-day operations of the program. This would affect how policy making and implementation in the public behavioral health arena had previously been undertaken. Would these experiences offer any insight into ways to break the micromanagement cycle in public agencies?
While Behn’s big questions of public management may not comprise all the issues of import to the subfield, attempting to answer them, muses Kettl (1996), continues to advance the entire field of public administration. As government has sought to reinvent itself it has increasingly looked outside of the realm of public administration and academics, gathering answers to government problems from the private sector, states Kettl. He attributes the need to do this to the “gap between the literature of political science and the answers that practitioners seek from it.” Additional study of questions and issues relevant to practitioners that also formalize theories of public administration will increase its value, not only to those seeking answers to practical problems, but to assuring that public administration continues as a central tenet to all of political science.
Chapter 3

Pennsylvania Public Behavioral Health

The public behavioral health system in Pennsylvania is complex. Two state departments and several offices within them have responsibility for portions of program oversight. A basic understanding of the system, from its early structure in the 1960s through the current evolution of programs and treatment delivery, is necessary here to set the context for the research. This chapter outlines in some detail the structure of the system, primary groups of actors, and the historical context for the move to HealthChoices.

Behavioral Health Regions

With the passage of the Pennsylvania Mental Health/Mental Retardation Act of 1966 (Pa. 50 P.S. §§ 4101 – 4704.) the commonwealth established the statutory base for the development of community-based services in mental health. The statute also provided for the oversight structure by the state for these new services under the auspices of the Department of Public Welfare (DPW) Office of Mental Health (OMH). The state was divided into four regions – Southeast, Northeast, Central, and Western – as indicated in Figure 3-1.
Within those regions, OMH staff operated from locally-based offices and provided technical assistance and policy oversight to county officials responsible for local human services programs and the providers delivering those services. In addition, regional OMH staff coordinated mental health services funded through Medicaid in the region with staff of the Office of Medical Assistance Programs.

A great deal of autonomy was provided to OMH officials in regional offices. Although guided by the same set of policies and regulations governing the delivery of services, individuals worked solely within a region and oversaw all mental health services in their geographic area, including oversight of state hospitals and other state-only funded treatment programs. Officials in the Southeast region, for example, had minimal contact with
those in the Western region. It was not unusual for providers delivering services among and between different regions to have widely disparate experiences in the licensing and delivery of the same type of treatment programs. Interaction styles and expectations developed between regional state officials, county officials, and provider groups that were specific to the geographic area.

With the decision to move to a mandatory Medicaid managed care program DPW realigned the regions, with the exception of the Southeast, to form the initial three geographic area (called “zones”) for the new HealthChoices policy. As shown in Figure 3-2 this realignment split the very large Western region, creating a Southwest managed care zone centered on the community of Pittsburgh; divided the Central region, separating the more populous counties in the eastern half to form the nucleus of a new zone (Lehigh/Capital); and added border counties from the southern end of the former Northeast region to complete the zone’s new geographic boundaries.
The new zones reflected the state’s attempt to group together the largest numbers of Medicaid-eligible persons without initially having to address some of the more difficult issues such as rural access to providers and treatment (Commonwealth of Pennsylvania, Department of Public Welfare, 1999). These new geographical divisions, however, were not identically reflected in the structure of DPW. Because each of the new managed care zones would also continue to have county delivered, state-funded mental health services that were not part of HealthChoices, the
original OMH regional oversight offices were maintained. Their responsibilities, however, changed dramatically.

Upon inauguration as governor in 1996, Tom Ridge combined much of the policy responsibility for mental health and substance abuse services in one office under the Department of Public Welfare. Previously, all substance abuse services and regulations were the responsibility of the Pennsylvania Department of Health. The creation of the new office – the Office of Mental Health and Substance Abuse Services (OMHSAS) – by the Ridge Administration laid the groundwork for implementation of the HealthChoices policy that included both mental health and drug and alcohol treatment. It also enabled the restructuring of responsibilities in the regional offices of the former Office of Mental Health.

In concert with the creation of OMHSAS and the development of HealthChoices, the department instituted implementation teams specific to the managed care product, bringing regional staff into new roles crossing traditional geographic boundaries. New state offices were created. The OMHSAS Bureau of Operations and Quality Management housed state oversight for HealthChoices and the OMHSAS Bureau of Financial Management and Administration was created to administer HealthChoices contracts with counties. This brought more of the oversight of behavioral health to centralized state employees. New relationships had to be developed among and between new groupings of counties, state officials assigned to
those counties but located in the Harrisburg offices, and those county entities created to administer HealthChoices. As well, new roles and responsibilities had to be learned at both the state and county government level.

To further understand Medicaid behavioral health services in the new geographic configuration a base knowledge of the five subsystems that control access to funding, program development, and delivery of services is required. These are central tasks in the implementation of the new policy. Those subsystems are state government, county government, managed care organizations, advocates and consumers, and providers and related interest groups.

**Pennsylvania Departments of Public Welfare and Health**

By federal requirement the Medical Assistance program in any state must fall under the jurisdiction of one office to assure that the state can accurately account for federal funds. In Pennsylvania that responsibility belongs to the Office of Medical Assistance Programs (OMAP) housed within the Department of Public Welfare. However, in moving the behavioral health system to the new HealthChoices model, oversight responsibility of that particular program was given to the Office of Mental Health and Substance Abuse Services. This decision was designed to assure that the new program focused not only on cost containment – a central theme in developing public
managed care across the country – but that the other major concerns such as access to treatment and the provision of quality services could also be maintained. The Department of Health, which houses the Bureau of Drug and Alcohol Programs and the Division of Licensing, would continue in their responsibilities of drug and alcohol provider licensing, including those treatment services included in HealthChoices even while oversight of service delivery in the three new geographic zones had been transferred to OMHSAS.

In order to move to HealthChoices as conceived by the state, Pennsylvania was required to seek a waiver from the federal government. This waiver, called a 1915(b) waiver because it eliminates some provisions within Section 1915 of the Social Security Act, allowed the state to change several requirements of the Medicaid behavioral health program. HealthChoices allowed Pennsylvania to:

- mandate enrollment of Medicaid beneficiaries,
- create the carve-out of behavioral health to separate treatment expenditures from those dollars spent on physical health,
- create a program that was not available statewide (implementing by regional zone),
- provide an enhanced service package moving additional treatment options under the Medicaid umbrella, and
• utilize cost savings to develop new service options previously unavailable to be funded with federal health care dollars (Centers for Medicare and Medicaid Services, 1998).

At the same time, HealthChoices enabled the state to delegate the detail of program operations to the counties while serving as the major purchaser of government funded health care. In this manner the state would no longer be responsible for such activities as program development and claims payment. Rather, it would now be responsible for large contracts purchasing health care for a group of people (Medicaid-eligible individuals), switching their focus to one of ensuring access, managing costs, and assuring the development of quality treatment services through monitoring and oversight of local government.

Pennsylvania County Government

Management of human services has been the responsibility of county government in Pennsylvania since the enactment of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (Pa. 50 P.S. §§ 4101 – 4704.) Provisions of the act state that county officials are responsible for delivery of nine primary habilitation and treatment services in the public sector. County government has taken this responsibility very seriously in the almost 40 years since the act’s provisions were established, developing systems of care
specific to identified needs of local populations. As such, state officials felt that giving county government responsibility for management of HealthChoices was a reasonable option. Counties were provided the “right of first opportunity” to run the new HealthChoices program in their local area (Collins, 1996). Through this opportunity, behavioral health treatment programs that had been locally developed over the course of many years and that provided essential services to individuals receiving care through the public system, could be retained in HealthChoices if desired. Additionally, because many county behavioral health services had been developed outside of the Medicaid funding stream, there was the hope that HealthChoices – if operated by the counties – would be more able to manage any services needed by an individual, regardless of federal or state funding category, as all services and funds management would be under the jurisdiction of one entity.

Government in each Pennsylvania county is controlled by elected commissioners or an elected county executive. In turn, those commissioners or executives are responsible for the oversight of all departments within their county. Pennsylvania counties differ in the structure of those departments as related to mental health, mental retardation, and drug and alcohol services. Some counties have human services administrators that oversee not only mental health and mental retardation services, but also drug and alcohol treatment, child welfare services, and juvenile justice. Other counties have not created those positions and the administrators of each of the individual
programs (mental health, drug and alcohol, child welfare, etc.) report directly to county commissioners or executives. In addition, some counties have joined efforts with each other in the provision of mental health and mental retardation services to form county joinders.\(^1\) Commissioners in these counties have chosen to share the development and administration of mental health and mental retardation programs with neighboring entities.

Development of the new HealthChoices zones did not require any county to change the way it structured management of their behavioral health programs. However, many chose to do so by creating new oversight entities, dissolving county joinders, or banding together in new configurations to select a managed care partner to administer the new policy.

Each Pennsylvania HealthChoices zone is comprised of several counties – five in the southeast, 10 in the southwest, and 10 in the Lehigh/Capital zone. County governments in these zones were given the option to implement HealthChoices as individual counties, groups of counties, or by deferring contracting back to the Department of Public Welfare. Since 1997 all three of those options have been used as counties implemented HealthChoices and developed contracts with managed care organizations to provide day-to-day operational management. For example, in Philadelphia

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\(^1\) County joinders are two or more counties that have come together to operate a single behavioral health program for citizen. Examples in Pennsylvania include Washington/Greene counties and Luzerne/Wyoming counties.
and Allegheny counties, county officials determined they would develop single county programs. However, Philadelphia opted to create a new managed care company run by the county while Allegheny contracted with an established managed care organization (MCO). In the Lehigh/Capital zone the five counties of Cumberland, Dauphin, Lancaster, Lebanon, and Perry joined together to form a “territory” to contract behavioral health services. As part of this development the counties also created an independent oversight organization responsible for ensuring that the behavioral health needs in all five counties were being adequately addressed while sharing resources. In Greene County (southwest zone) initial implementation planning efforts were not successful. The Washington/Greene joinder dissolved, and while Washington County joined other nearby counties in contracting services with a managed care company, Greene County eventually opted to not assume risk for the new program and returned control of HealthChoices to the Department of Public Welfare, which then contracted those services directly with a MCO. Table 3-1 lists by county the oversight entity and the contracted managed care organization.
Table 3-1: County Oversight and MCO Affiliation

<table>
<thead>
<tr>
<th>County</th>
<th>Oversight</th>
<th>MCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bucks</td>
<td>Bucks County Behavioral Health</td>
<td>Magellan, Inc. of PA</td>
</tr>
<tr>
<td>Chester</td>
<td>Chester Office of Behavioral Health</td>
<td>Community Care Behavioral Health Organization</td>
</tr>
<tr>
<td>Montgomery</td>
<td>Montgomery Office of Behavioral Health</td>
<td>Magellan, Inc. of PA</td>
</tr>
<tr>
<td>Delaware</td>
<td>DelCare</td>
<td>Magellan, Inc. of PA</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>City of Philadelphia</td>
<td>Community Behavioral Health</td>
</tr>
<tr>
<td>Allegheny</td>
<td>Allegheny County Health Choices, Inc.</td>
<td>Community Care Behavioral Health Organization</td>
</tr>
<tr>
<td>Beaver</td>
<td>Beaver County</td>
<td>Value Behavioral Health of PA</td>
</tr>
<tr>
<td>Fayette</td>
<td>Fayette County</td>
<td>Value Behavioral Health of PA</td>
</tr>
<tr>
<td>Greene</td>
<td>OMHSAS</td>
<td>Value Behavioral Health of PA</td>
</tr>
<tr>
<td>Southwest 6: Westmoreland, Washington, Indiana, Armstrong, Butler, Lawrence Counties</td>
<td>Southwest Behavioral Management, Inc. Each County also has oversight responsibilities</td>
<td>Value Behavioral Health of PA</td>
</tr>
<tr>
<td>Berks</td>
<td>Berks County</td>
<td>Community Care Behavioral Health Organization</td>
</tr>
<tr>
<td>York/Adams</td>
<td>York/Adams County</td>
<td>Community Care Behavioral Health Organization</td>
</tr>
<tr>
<td>Lehigh</td>
<td>Lehigh County</td>
<td>Magellan Inc. of PA</td>
</tr>
<tr>
<td>Northampton</td>
<td>Northampton County</td>
<td>Magellan Inc. of PA</td>
</tr>
<tr>
<td>Capital 5: Dauphin, Cumberland, Perry, Lancaster, Lebanon</td>
<td>Capital Area Behavioral Health Collaborative</td>
<td>Health Assurance/Community Behavioral Care Network of PA</td>
</tr>
</tbody>
</table>

Source: [http://www.dpw.state.pa.us/LowInc/BehaveMentalHealth/003670135.htm](http://www.dpw.state.pa.us/LowInc/BehaveMentalHealth/003670135.htm)
Managed Care Organizations

Five managed care organizations (MCOs) currently contract with counties to provide behavioral health access, treatment authorization and utilization review, develop and maintain provider networks, administer claims payments, and assure quality for covered Medicaid populations. Those companies include both for-profit and not-for-profit ventures. Three MCOs were established in direct response to the implementation of HealthChoices while the remaining two certify care nationally. The companies are competitors, yet at the same time find themselves occasionally acting in concert to respond to the state subsystem.

Community Behavioral Health

Community Behavioral Health is a not-for-profit launched in 1996 by county government to manage services for and with Philadelphia County. Philadelphia officials had long been preparing for public sector managed care. A Robert Wood Johnson Foundation grant received in the late 1980s had provided the city with funds for several years to explore the behavioral health delivery system and develop infrastructure to improve the delivery of care

2 Additional history regarding the structure and governance of Community Behavioral Health can be found at http://www.phila-bhs.org.
(Flannery, 1995). Through this process and experience with voluntary managed care in Philadelphia, county officials determined they wished to retain control of all health care dollars rather than subcontracting to another company to manage those dollars or authorize and pay for treatment.

**Magellan Behavioral Health**

Magellan Behavioral Health (MBH) is a for-profit MCO that manages commercial and public behavioral health services in 50 states. Magellan Behavioral Health currently has more than 30 percent of the managed behavioral health care market share in the country, combining public sector and commercial contracts. MBH in Pennsylvania administers HealthChoices as the subcontracted MCO for Bucks, Montgomery, and Delaware counties. Magellan brought national experience in the management of behavioral health to Pennsylvania operations, stating they could assure counties that they had the infrastructure necessary to successfully mitigate financial risk to county governments.

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3 Additional details about Magellan Behavioral Health, including Pennsylvania-specific HealthChoices information is available at [http://www.magellanhealth.com](http://www.magellanhealth.com).
Value Behavioral Health of Pennsylvania

Value Behavioral Health of Pennsylvania, Inc. (VBH-PA) is also a for-profit MCO managing commercial and public services. ValueOptions, the parent company of VBH-PA, holds public and private contracts nationwide. Ten of those contracts are state public behavioral health contracts. They, like Magellan, assured counties they had the necessary infrastructure to manage risk that would be assumed when counties exercised their first right of opportunity to operate HealthChoices. The Pennsylvania program is the HealthChoices MCO for Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland counties.

Community Care Behavioral Health Organization

Community Care Behavioral Health Organization (CCBH) is a not-for-profit MCO that was established by St. Francis Hospital and the University of Pittsburgh Medical Center in response to creation of HealthChoices by the commonwealth. CCBH has grown since its inception in 1997 to provide both

public and commercial services in Pennsylvania and Connecticut. CCBH currently serves Allegheny, Berks, Chester, and York/Adams counties in Pennsylvania HealthChoices.

Community Behavioral HealthCare Network of Pennsylvania

Community Behavioral HealthCare Network of Pennsylvania, Inc. (CBHNP) is a not-for-profit collaborative of behavioral health providers with a long history of service provision to persons who received treatment through public sector funding. The collaborative wanted to assure that access to quality services remained available for the populations they served – those persons with the most serious mental illnesses – as managed care entered the behavioral health system and felt they had the experience necessary to create a company to do so. Although originally designed to serve only constituents in the public managed care arena, CBHNP also holds commercial contracts in Pennsylvania. CBHNP is the MCO contractor for Cumberland, Dauphin, Lancaster, Lebanon, and Perry counties.

5 Located on the Internet at http://www.ccbh.com, additional information about the history and development of Community Care Behavioral Health is available. 
6 Additional history regarding the structure and governance of Community Behavioral HealthCare Network of Pennsylvania can be found at http://www.cbhnp.org.
Providers and Other Related Interest Groups

Thousands of providers in hundreds of treatment facilities deliver services as part of the provider networks contracted and enhanced by MCOs. Pennsylvania required an “any willing provider” status of all HealthChoices MCOs, meaning that any provider holding license from the state to deliver behavioral health treatment through the Medicaid program was eligible to join HealthChoices provider networks. They did, however, have to meet any additional credentialing requirements imposed by the MCOs. Large community mental health centers, private companies, individual practitioners, and entrepreneurs beginning new treatment programs as opportunities were made available, are all included. Some agencies/individuals are part of only one MCO provider network. Others, such as residential treatment facility providers for children and adolescents, are credentialed by all five MCOs because of the specificity and/or scarcity of the service they offer.

Public system providers, long accustomed to collaborating to care for Medicaid populations, suddenly found themselves competitors in the Medicaid managed care arena. In addition to the community providers with a long history of service delivery to Medicaid-eligible people in specific areas, new providers developed services as a direct result of the HealthChoices requirement for provider choice within geographic areas. Where, for example,
there had once been only one provider of partial hospital services in a city and all persons requiring that level of care were seen by one agency, HealthChoices now required counties and their MCO partners to develop at least two options for treatment at every level of care. Providers accustomed to specializing in one area and referring individuals to other agencies for ongoing treatment suddenly found themselves no longer “guaranteed” a certain number of clients. These new rules required providers to form different relationships with MCOs and counties to assure their continued existence in a new culture.

A variety of other interest groups join this subsystem of the Pennsylvania behavioral health system. These include groups such as the Pennsylvania Community Providers Association – a trade association whose members provide mental health, drug and alcohol, mental retardation, and children’s services⁷ – and the Mental Health/Mental Retardation Program Administrators Association of Pennsylvania (MH/MR PAAP) – an affiliate of the County Commissioners Association whose membership is comprised of the 49 county/county-joinder mental health/mental retardation and human services administrators.⁸

Though not directly involved in the delivery of treatment services, groups of this nature work with those they represent to refine regulations, ________________________________

lobby elected leaders and state officials for program enhancements to benefit their constituents, and interpret policy for their members. Whether regional or statewide in membership, these groups see as a primary responsibility the influence of decision making in public sector services.

**Advocates and Consumers**

The HealthChoices policy added a new dimension to the development and oversight of behavioral health care. Consumers (those who have had or are currently receiving services) and advocates (disability law projects, family members, and others representing consumers) had previously created organizations to assure that services received met their needs. However, it was a generally accepted fact that they really had very little “voice” in the determination of what services were available to them. HealthChoices required partnerships between counties, MCOs, providers, and consumers and advocates (Commonwealth of Pennsylvania, Department of Public Welfare, 1999). Oversight panels at all levels (state, county, and MCO) were required by standards to include significant consumer/advocate representation (Commonwealth of Pennsylvania, Department of Public Welfare, 2001). As well, the complaint and grievance system within HealthChoices was designed to provide the individual with more choice of
treatment and provider and a formal avenue to express concern, as well as enhance their impact and involvement in the behavioral health system.

The advocacy community, which includes groups such as the National Alliance for the Mentally Ill – Pennsylvania, the Pennsylvania Mental Health Consumers’ Association, and the Pennsylvania Health Law Project, were all involved in the development and implementation of HealthChoices, both at the state and individual county level.

**Beginning Pennsylvania HealthChoices**

Pennsylvania HealthChoices was formally described in detail by the Department of Public Welfare to the remainder of the behavioral health system through the first HealthChoices Request for Proposal (RFP) released in March 1996. Initially to be effective in November of that same year, the state planned to “introduce a new integrated and coordinated health care delivery system to serve Medical Assistance eligible persons who require medical, psychiatric, and substance abuse services through a capitated, mandatory managed care program” (Commonwealth of Pennsylvania, Department of Public Welfare, 1996, p. 3).

Decisions about the final form of the HealthChoices program came about following two significant trends in the management of public health care. Although HealthChoices was to be a mandatory program, Medicaid
managed care was not new to Pennsylvania. Since the early 1990s the state had been experimenting with voluntary managed care in a number of areas, most notably the Southeast region (Flannery, 1994; Roche, 1994, 1995; Collins, 1995). These experiments were not perceived to be going well as millions of dollars were being diverted away from care and into company profits by the health maintenance organizations (HMOs) overseeing both physical and behavioral health care. Those dollars were seen primarily as savings from very low authorization and reimbursement rates for behavioral health (Roche, 1994). Members of the behavioral health community (county government, providers, advocates, and consumers) did not believe the HMOs were providing enough service or the right kind of service to effectively assist individuals in managing mental illnesses.

Second, across the country the costs of health care were rising exponentially and more people were seeking government assistance for treatment. Medicaid was designed as an entitlement program by the federal government in the 1960s. As the economy slowed in the early 1990s and more individuals were unemployed or underemployed and became eligible for government health care benefits, costs were driven up because the system was unable to refuse services to those who qualified (Coffey, et.al., 2000). At the same time new federal programs such as the Early, Periodic, Screening, Testing and Diagnosis (EPSDT) program were being put into place that required states to provide treatment for any condition identified through
program screening. States were encouraged to make use of these programs to ensure the health and well-being of disadvantaged citizens, most notably children. While it was hoped that these programs would prevent the onset of more costly illnesses and treatments, the explosion of authorized services resulting from them was not foreseen, especially in behavioral health. Suddenly there was a very large demand for treatment programs and the system was strained in its ability to meet those demands (Judge David L. Bazelon Center for Mental Health Law, 2000). Costs were spiraling upward as additional health issues were detected, including behavioral health, and more services demanded by recipients.

Amidst the issues and resulting strain on the public system, state officials and other subsystem representatives sought new avenues for the management of public health that would better serve eligible persons. This resulted in the development of the 1915(b) Pennsylvania Medicaid waiver that carved out behavioral health from physical health and gave counties the first right of opportunity in managing the new system.

The Behavioral Health Carve-Out

As noted, voluntary managed care programs in Pennsylvania that had been operational prior to HealthChoices did not carve out behavioral health. Instead, large health maintenance organizations were contracted to manage
service delivery for both physical and behavioral health for beneficiaries. As part of that process, behavioral health services were often not authorized and people were unable to receive treatment. Governor Casey, in office from 1987 – 1995, attempted during that time to begin the mandatory HealthChoices program, leaving behavioral health services carved in, as it was in HealthPass, the largest of the voluntary managed care programs operating in Philadelphia County. Casey sought to secure bidder responses to a state generated request for proposal to HMOs to operate the new system worth hundreds of millions of dollars. During this time the advocacy community engaged the media (print and television) to expose what they indicated were dramatic problems in the system as it related to behavioral health care. Through this process it became evident that the HMOs were making millions of dollars in profit in the voluntary managed care programs and that behavioral health treatment was not being authorized. Lawsuits were filed to stop the advancement of the program (Flannery, 1994).

Simultaneously, the election process for a new governor was underway and the issue had an impact even during the campaign process. Candidate Tom Ridge did not support the current Medicaid program design under legal contention and indicated that if elected he would pursue other avenues for Medicaid. Ridge was elected governor and began his term in 1995. Once elected and during the process of shaping the new administration, Ridge put a halt to the HealthChoices request for proposal process as it had been
constructed by the Casey Administration in order to determine what the best
direction would be to move forward. It was this process slowdown that
provided the opportunity for the community to advocate for a carve-out of
behavioral health to assure that necessary mental health and substance
abuse services could be delivered and paid for as part of the Medicaid
program.

Each subsystem involved in the public behavioral health system
supported the carve-out of funding and also, with the exception of managed
care organizations, supported the county right of first opportunity to operate
Although there were a variety of issues and needs on the table from the
different groups, the desire of counties, providers, and advocates to maintain
a separate behavioral health system was the impetus needed to allow the
Ridge Administration to alter HealthChoices as designed by Governor Casey.

Summary

By accepting the carve-out with the county right of first opportunity,
Pennsylvania developed a public behavioral health policy that was state
supervised and county administered. A considerable amount of autonomy
and flexibility was devolved to counties to design and implement the
Medicaid program as they saw fit, building on previous experiences governing
state-funded behavioral health treatment. This autonomy and flexibility, however, remained constrained within federal and state-mandated requirements included in the 1915(b) waiver granted by the federal government that outlined Pennsylvania intent for the governance of HealthChoices. The first implementation of behavioral HealthChoices in the Southeast zone began in 1997. This structure provides the context for exploring differences in perceived influences among and between implementation zones in the commonwealth.
Chapter 4

Methodology

The literature, as noted, supports the existence of a relationship between policy implementation and the officials, bureaucrats, and other policy actors involved in the implementation process (Bardach, 1977; Edwards, 1980, 1984; Ingram, 1990; Nakamura & Smallwood, 1980; Pressman & Wildavsky, 1984; Rein & Rabinovitz, 1978; Schneider, 1982; and Nownes & Freeman, 1998). Additional focus from the interest group literature provides information about the relationships between actors and how those relationships are used to affect policy implementation (Thurber, 1991; Cammisa, 1995; Schneider & Jacoby, 1996; Frank & Morlock, 1997; and Loomis & Cigler, 2002). This study, in building on that base, sought to add to the research literature by describing how the perceived influence of individuals and groups affected the implementation of state health policy.

This chapter reviews the research question and propositions, describes the research setting and research participants, and outlines data collection methods and the method of data analysis.
Research Question and Propositions

The study addressed how the perceived influence of particular actors and/or groups affects the implementation of public policy. Stated more specifically the research question becomes “Is regional implementation of behavioral health policy in Pennsylvania changed by the involvement and/or influence of officials, bureaucrats, and other actors in the policy environment?” Data were gathered primarily through structured interviews with individuals involved in the Pennsylvania public behavioral health system. Their responses were supplemented by the review of historical documents related to the system. The researcher’s role as a participant-observer in the system prior to the beginning of data collection provided the base for conceptualizing the study. A series of exploratory propositions were established by the researcher prior to the beginning of data collection to further examine the research question and generate ideas for further study. Those propositions are:

- Perceptions of influences that affect the implementation of behavioral health in Pennsylvania are consistent across regions that have implemented the Medicaid managed care program, HealthChoices.
- The perceived impact of influence at the county government level is greater than the impact of perceived influence of the state
bureaucracy in program implementation, creating differences in the HealthChoices program across regions.

- A collaborative relationship between county government and the contracted managed care organization increases variance in implementation from the HealthChoices program as defined by the state.

**Research Setting**

The research was a limited single-state case study, designed as an exploratory study to identify relationships and actions that affect the implementation of a public policy. Because of the researcher’s long-term involvement in the Pennsylvania public behavioral health system the opportunity existed to gather data not previously accessible to collective observation. The researcher had access to participants from all five subsystems identified in Chapter Three as constituents in the public behavioral health arena. Available research to date in this particular setting has not focused on the entire spectrum of participants. Such comprehensive descriptive information offered the ability to explore alternative explanations from those presented in the literature for variations in the implementation of the policy (Birnbaum, 1998; Johnston, 2003; and Weissert, 2003).
The research is a limited case study because Pennsylvania has not implemented the HealthChoices policy in all geographic regions. Rather, within the state three geographic zones, defined by clusters of counties, were selected to implement the policy on a rolling time basis. Implementation was started in only one zone at a time. Zones were selected by the state based on numbers of Medicaid-eligible individuals, proximity to urban settings, perceived readiness to implement managed care, and the robustness of the current service delivery system (Department of Public Welfare [DPW], 2005).

Although the initial intent of officials was to complete the implementation of HealthChoices throughout the state by the end of 2005, only 25 counties in three zones are operational (DPW, 2005).

Each zone – Southeast, Southwest, and Lehigh/Capital – is defined by geographic county borders. The Southeast zone includes five counties and there are 10 counties in both the Southwest and Lehigh/Capital zones. Within each zone more than one HealthChoices program is operational. Individual county governments could choose to implement the policy as a single-county entity or by joining with neighboring counties. Figure 4-1 identifies, by zone, which counties operate as single-entities and which have joined with others to implement behavioral HealthChoices.
<table>
<thead>
<tr>
<th>Zone</th>
<th>County</th>
<th>Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southeast</td>
<td>Bucks</td>
<td>Individual</td>
</tr>
<tr>
<td>Southeast</td>
<td>Chester</td>
<td>Individual</td>
</tr>
<tr>
<td>Southeast</td>
<td>Delaware</td>
<td>Individual</td>
</tr>
<tr>
<td>Southeast</td>
<td>Montgomery</td>
<td>Individual</td>
</tr>
<tr>
<td>Southeast</td>
<td>Philadelphia</td>
<td>Individual</td>
</tr>
<tr>
<td>Southwest</td>
<td>Allegheny</td>
<td>Individual</td>
</tr>
<tr>
<td>Southwest</td>
<td>Beaver</td>
<td>Individual</td>
</tr>
<tr>
<td>Southwest</td>
<td>Fayette</td>
<td>Individual</td>
</tr>
<tr>
<td>Southwest</td>
<td>Green</td>
<td>Individual</td>
</tr>
<tr>
<td>Southwest</td>
<td>Westmoreland, Washington, Indiana, Armstrong, Butler, and Lawrence</td>
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</tr>
<tr>
<td>Lehigh/Capital</td>
<td>Berks</td>
<td>Individual</td>
</tr>
<tr>
<td>Lehigh/Capital</td>
<td>Cumberland, Dauphin, Lancaster, Lebanon, and Perry</td>
<td>Collective</td>
</tr>
<tr>
<td>Lehigh/Capital</td>
<td>Lehigh</td>
<td>Individual</td>
</tr>
<tr>
<td>Lehigh/Capital</td>
<td>Northampton</td>
<td>Individual</td>
</tr>
<tr>
<td>Lehigh/Capital</td>
<td>York and Adams</td>
<td>Collective</td>
</tr>
</tbody>
</table>

Figure 4-1: HealthChoices County Structures
As noted in Figure 4-1, there are 15 separate instances of implementation of the HealthChoices behavioral health policy in three zones. This research retains its focus on differences among and between the three zones. However, it is important to note that there are several programs operational in a specific zone which may affect responses of research participants, providing an additional level of data for future consideration.

The public behavioral health system in Pennsylvania also includes participants from five subsystems, as noted in Chapter Three. Those subsystems include state government, county government, managed care organizations, providers and other related interest groups, and advocates/consumers.

**Research Timeframe**

As often with case study research (Yin, 1994), data in this study include historical information from the initial implementation of the behavioral HealthChoices policy. The time boundary for implementation of HealthChoices for this study begins in May 1995 and ends in October 2001. During that period the three zones completed implementation; Southeast in 1997, Southwest in 1999, and Lehigh/Capital in 2001. During this time period the policy was drafted by Pennsylvania state officials, approved by the
federal government, and operational contracts established between county and state government to implement the policy. Additional detail about the process and activities undertaken during this time period are noted in Chapter 3, which outlines public behavioral health policy in Pennsylvania.

Actual data collection through interviews and document review was conducted from May – September 2005.

Research Design

Beginning with the stated research question – “Is regional implementation of behavioral health policy in Pennsylvania changed by the involvement and/or influence of officials, bureaucrats, and other actors in the policy environment?” – the researcher completed an in-depth review of background information related to the public behavioral health system in Pennsylvania. This included review of personal notes, proprietary documents, and memos gathered during her time as a participant-observer in the system. From that review the researcher further defined the study through the crafting of three exploratory propositions.

Based on those propositions the decision was made to seek data at the regional level in an effort to gain more comprehensive information about how implementation occurred. It was also at this point the determination was made to secure information about each of the five subsystems in the public
behavioral health arena. Two avenues of information sources were selected. Primary data would come from interviews with individuals noted during the background review as being extensively involved in implementation.

Secondary data would come from an extensive document review including information published by the state of Pennsylvania, county government and affiliated oversight companies, managed care organizations, and the mass media.

Interview Question Development

The researcher crafted 24 open-ended questions to obtain data from participants. These questions are listed in their entirety and in numerical order in Appendix A. Questions were designed to (a) provide additional support or refute background information already collected, (b) gain information specific to each proposition, or (c) to determine if there were other factors aside from the perceived influence of individuals or groups of actors that respondents believed affected differences noted among and between HealthChoices zones.

Figure 4-2 identifies questions drafted to address background information gathered prior to the beginning of data collection.
Pennsylvania’s carve-out of behavioral health dollars from Medicaid physical health is referred to as a pivotal decision point in the development of the HealthChoices program. What opportunities did that provide?

What problems or difficulties did it create?

Who do you believe were key players in the determination of carve-out and what impact did they have?

Figure 4-2: Interview Questions Addressing Background Information

Most questions were designed to provide data related to each of the three exploratory propositions. The researcher expected that some questions would provide information addressing more than one proposition. Figure 4-3 identifies questions related to Proposition #1: Perceptions of influences that affect the implementation of behavioral health in Pennsylvania are consistent across regions that have implemented the Medicaid managed care program, HealthChoices.
The process of developing the regulations/policies guiding HealthChoices was lengthy. Was that a public process or limited to selected participants? Were you involved?

Do you believe the implementation of HealthChoices has changed over time (zone to zone)? How and why/why not?

There are differences in how HealthChoices “looks” between and within implementation zones. What do you think accounts for those differences?

Have there been leadership changes during HealthChoices implementation that have effected program change? Please provide examples.

Does the MCO structure (local/national, for profit/non-profit, age/experience) have any impact on the level of influence exhibited by county officials in local implementation? How and why?

Does the county structure (single/joinder/territory, leadership experience) have any impact on the level of influence exhibited by county officials in local implementation? How and why?

What role have advocacy organizations and other interest groups had in affecting the implementation designs of HealthChoices?

Has that varied across regions? How?

Do those interest groups provide more impact locally or statewide?

Figure 4-3: Interview Questions Addressing Proposition One

Figure 4-4 identifies questions seeking data related to Proposition #2:

The impact of perceived influence at the county government level is greater than the impact of perceived influence of the state bureaucracy in program
implementation, creating differences in the HealthChoices program across regions.

When PA first announced its move to Medicaid managed care through the HealthChoices waiver, what changes did you expect to see?

Did those changes occur? Immediately or over time? Were those changes a result of particular individuals involved in the development of the program?

How did you feel the PA model compared to other state initiatives that had already been implemented? Do you feel PA built the HealthChoices model on “lessons learned” from other states?

The process of developing the regulations/policies guiding HealthChoices was lengthy. Was that a public process or limited to selected participants? Were you involved?

Do you believe the implementation of HealthChoices has changed over time (zone to zone)? How and why/why not?

Who were the people that had the greatest impact on the shaping of those policies and regulations? Why?

What influences shape the distinctions between HealthChoices programs in various counties (e.g. what services to include, practice patterns, etc.)?

Does the county structure (single/joiner/territory, leadership experience) have any impact on the level of influence exhibited by county officials in local implementation? How and why?

Who has the greatest influence on the implementation model in a specific zone – the state, the county, or others?

Figure 4-4: Interview Questions Addressing Proposition Two
Figure 4-5 identifies questions related to Proposition #3: A collaborative relationship between county government and the contracted managed care organization increases variance in implementation from the HealthChoices program as defined by the state.

When Pennsylvania first announced its move to Medicaid managed care through the HealthChoices waiver, what changes did you expect to see?

Did those changes occur? Immediately or over time? Were those changes a result of particular individuals involved in the development of the program?

What influences shape the distinctions between HealthChoices programs in various counties (e.g. what services to include, practice patterns, etc.)?

Does the MCO structure (local/national, for profit/non-profit, age/experience) have any impact on the level of influence exhibited by county officials in local implementation? How and why?

Who has the greatest influence on the implementation model in a specific zone – the state, the county, or others?

Figure 4-5: Interview Questions Addressing Proposition Three

Finally, the researcher crafted questions to gather data about whether respondents believed there were factors aside from the perceived influence of individuals or groups that affected differences noted among and between HealthChoices regions. Those questions are listed in Figure 4-6.
What factors outside of the direct interactions among and between state officials, county officials, and MCOs has affected implementation of HealthChoices?

Have any of these factors had more influence on the program than others?

What other information do you believe is pertinent to understanding how influence affects HealthChoices implementation?

Figure 4-6: Interview Questions Addressing Additional Factors

Selection of Interview Participants

In a study of perceived influence, conversations with subsystem actors form a critical stream of information. Some participants selected for this study, because of the historical nature of the research, are no longer involved in Pennsylvania Behavioral HealthChoices. However, inclusion of these persons helped assure that the researcher gathered data rich in detail not known to others or available in historical documents.

The original list of participants was comprised of those individuals identified by the researcher as primary actors in the development and implementation of HealthChoices. These decisions were based on including those named in background literature as integral to the development of the policy and information gathered as a participant-observer in the system during prior years of policy implementation. During interviews, respondents
were also asked to identify others they felt should be included in the study. Efforts were made to secure participation from individuals representing each of the five subsystems and who were also able to share perceptions of more than one subsystem. For example, an individual employed by a managed care organization would be asked to reflect on the perceived influence of state and county government officials, advocates, and providers, in addition to managed care entities. Respondents needed to have both breadth and depth of involvement with others in the public behavioral health system.

**Recruitment of Interview Participants**

Individuals were first contacted by the researcher via electronic mail explaining the research to be undertaken and asking for participation based on their involvement in one or more of the subsystems integral to the study. An electronic letter request (see Appendix B) was sent directly by the researcher to each individual. A copy of the electronic mail request, date and time stamped, was retained by the researcher. The letter asked that if the individual was willing to participate they respond to the request via electronic mail, telephone, or facsimile.

After a period of one week, if an individual had not responded to the electronic mail request, the researcher placed a telephone call to the person briefly explaining the research, referencing the original electronic mail
request, and again asking for their participation. If the individual could not be reached directly, a voice mail message was left and they were asked again to contact the researcher. Finally, if there was no response to either the first or second request, the researcher made a final attempt to secure participation by sending the original letter via United States Postal Service to the person.

Additional potential participants identified by individuals during interviews were contacted in the same manner. Twenty-three (23) persons were initially identified by the researcher from whom to request participation. During the course of the interviews an additional six persons were identified. Of those requests, 20 individuals agreed to participate. Seventeen (17) were those originally selected by the researcher and the remaining three were those identified by respondents. Of the 20 individuals who participated, 17 responded to the initial electronic mail request to participate and the remaining three responded following a telephone call placed by the researcher.

Participants were selected based on their ability to provide information about more than one subsystem involved in the research. The study also sought to include interviews from individuals representing each of the five subsystems. Two of the participants no longer work in the Pennsylvania behavioral health system. Of the remaining 18, nine remain in the same employment they held during the historical time boundary for the study (May 1995 – October 2001). The other nine have changed employment during that
time, though all remain within the public behavioral health system in Pennsylvania. Figure 4-7 identifies the current subsystem of respondents and their previous subsystem involvement.
<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Current Subsystem</th>
<th>Previous Subsystem(s)</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>#2</td>
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</tr>
<tr>
<td>#3</td>
<td>State Government</td>
<td>County Government</td>
</tr>
<tr>
<td>#4</td>
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</tr>
<tr>
<td>#5</td>
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<td>State Government</td>
</tr>
<tr>
<td>#6</td>
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<td>State Government</td>
</tr>
<tr>
<td>#7</td>
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</tr>
<tr>
<td>#8</td>
<td>County Government</td>
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</tr>
<tr>
<td>#9</td>
<td>County Government</td>
<td>County Government</td>
</tr>
<tr>
<td>#10</td>
<td>County Government</td>
<td>County Government</td>
</tr>
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<td>Provider/Related Interest Group</td>
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<td></td>
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</tr>
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<td>#18</td>
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<tr>
<td>#19</td>
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<td>County Government</td>
</tr>
<tr>
<td>#20</td>
<td>State Government</td>
<td>Consumer/Advocate</td>
</tr>
</tbody>
</table>

Figure 4-7: Affiliation of Research Participants
Data Collection

Effective case study research, even of an exploratory nature, attempts to show a convergence of data elements to lead the researcher to identify support for concluding statements (Yin, 1994). Data were gathered primarily through conducting structured interviews with 20 participants identified as knowledgeable about the research question. An extensive document review was then conducted seeking support for responses from interviews.

Interview Scheduling

After agreeing to participate an interview was scheduled by the researcher. Participants were asked to allow 60 – 90 minutes for the interview. Interview dates and times were chosen by the respondent. The individual could schedule a face-to-face or telephonic interview. Seven persons elected to complete face-to-face interviews. Thirteen were interviewed telephonically.

During the scheduling process individuals were informed of the need to complete a signed consent form agreeing to their participation in the study. Approved by the Penn State Office for Research Protections, the consent form is available in Appendix C. For those interviews scheduled face-to-face the researcher took two copies of the consent form to the meeting. Consent was reviewed and signed by the participant prior to beginning the interview. A
copy was provided to the respondent for their records. For interviews conducted telephonically, the consent form was sent electronically at the time the interview was scheduled. The respondent was asked to review and sign the form, keeping a copy for themselves and returning a signed and dated copy via facsimile. Informed consent was obtained from all 20 participants prior to beginning the scheduled structured interview.

The researcher used the interview questions as outlined in Appendix A. Questions were sent to the participant seven days (one week) prior to the scheduled meeting. This allowed the individual to review the questions prior to the scheduled interview if desired. The researcher deliberately chose the option of sending questions ahead of time. The Pennsylvania HealthChoices policy is broad and has a variety of different components. The researcher wished to identify for respondents the particular issues within the policy that were the focus of the research. Every respondent indicated that they reviewed the questions prior to the interview and found that having them ahead of time aided them in organizing their thoughts.

**Interview Completion**

The first interview was completed on May 24, 2005 and the final interview was completed on August 18, 2005. Interviews ranged in length from 55 – 95 minutes. There appear to be no significant patterns related to
the length of the interview based on the participant's affiliated subsystem.

There also does not appear to be any relationship to length of time of interview and whether it was conducted face-to-face or telephonically.

Fourteen of the 20 interviews fell within a 60 – 75 minute range. Both the shortest and the longest interview were completed telephonically.

Based on prior professional work experience by the researcher with many of the individuals, the range of times was not unexpected. Personal conversation styles of individuals vary, especially when relating information about this particular behavioral health policy. Figure 4-8 indicates the length of time of each interview, the format (face-to-face or telephone), and the current subsystem affiliation of those interviewed.
<table>
<thead>
<tr>
<th>Interview Type</th>
<th>Length</th>
<th>Current Subsystem</th>
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</thead>
<tbody>
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<td>None</td>
</tr>
<tr>
<td>Telephone</td>
<td>78</td>
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</tr>
<tr>
<td>Face to Face</td>
<td>75</td>
<td>State Government</td>
</tr>
<tr>
<td>Telephone</td>
<td>81</td>
<td>State Government</td>
</tr>
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<td>Telephone</td>
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</tr>
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<td>60</td>
<td>County Government</td>
</tr>
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<td>County Government</td>
</tr>
<tr>
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<td>County Government</td>
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<tr>
<td>Face to Face</td>
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<tr>
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<tr>
<td>Telephone</td>
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<td>County Government</td>
</tr>
<tr>
<td>Face to Face</td>
<td>60</td>
<td>Consumer/Advocate</td>
</tr>
</tbody>
</table>

Figure 4-8: Interview Length and Format

During the interview the researcher took extensive notes of comments supplied by the respondent. These notes were then transcribed into an electronic record by the researcher, retaining their narrative form. This
transcription was completed within 24 hours of each interview. Each participant was offered the opportunity to review the transcript for accuracy. Each declined a formal review. All indicated their willingness to provide additional information or provide clarity if, during transcription, the researcher had additional questions. The researcher did not re-contact any individual.

**Interview Database Construction**

A research database was developed using SPSS software. Fields were established from the various questions asked. Responses were coded based on keywords in answers (determined by the researcher) and a codebook was established to assure that as data were gleaned from interviews similar responses were coded identically. The database codebook can be found in Appendix D. Not all of the information gathered from participants was easily able to be coded by keyword. Much of the context of responses needed to be retained in order to fully understand the response and to not risk oversimplifying comments. For that reason comprehensive narrative summaries were also retained by the researcher that assured the richness of detail included in the actual comments was available during data analysis.
Document Review

Written documentation about the implementation of HealthChoices is robust. In addition to mass media accountings of the policy a multitude of reports and bulletins are readily available to the public. These include HealthChoices Requests for Proposals (RFP), county RFP responses, state administrative reports, county administrative reports, managed care organization administrative reports, interest group papers and articles, legal actions, and evaluation/outcome studies.

The researcher developed a template to guide the review of these materials (see Appendix E). This template assisted in categorizing implementation methods reported, references to activities of subsystem actors, and determining which of the propositions were reflected in materials reviewed. Information was coded based on keywords located in the documents (determined by the researcher) and a codebook was established to assure that as data were gleaned from documents similar information could be sorted. Documents included in the review are listed in their entirety in Appendix F.

In addition to keywords, the researcher assigned documents to specific propositions based on information culled during the review. Some documents reflected information related to only one proposition, particularly newspaper articles. Others, such as the state requests for proposals and annual reports of managed care organizations, offered information related to more than one
of the study propositions. Documents were also assigned a code to identify which region or regions were addressed.

By completing such an extensive review, the researcher sought data to supplement statements made by interview participants by finding historical information that supported or disagreed with reflections of respondents shared during the structured interviews.
Chapter 5
Research Findings and Discussion

Beginning in 1997 a new policy for the implementation of Medicaid behavioral health treatment was initiated in Pennsylvania. Since that time many studies were undertaken to determine the effectiveness of various parts of the policy – HealthChoices – and the ability of the state to meet their stated goals in moving to this new structure. Many of these studies focused on access to care, complaints and grievances, service usage, and costs.9 Others addressed the design of the policy and the governmental teams put in place to provide oversight (Johnston, 2003). None, however, addressed whether relationships among actors contribute to why the policy varies in the way it is implemented in the three Pennsylvania zones. This research sought to answer the question: “Is regional implementation of behavioral health policy in Pennsylvania changed by the involvement and/or influence of officials, bureaucrats, and other actors in the policy environment?”

Through the use of structured interviews with actors in the system, coupled with an historical document review, data were collected on a regional

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9 For example, The Commonwealth of Pennsylvania, Office of Mental Health and Substance Abuse Services provided quarterly Behavioral Health Choices Early Warning Reports, beginning in 2000. These reports have been reviewed as part of this study and are included in Appendix F.
basis to address the research question. Findings of that data collection are discussed here by zone and specific underlying propositions.

Ascertaining Change

In order to address why regional implementation has changed the researcher first sought to determine if respondents felt there was indeed a difference in how the policy had been implemented across zones. Culling and tabulating responses, frequencies noted in Table 5-1 indicate that the majority of those interviewed believe that changes occurred in implementation over time and in each zone.

<table>
<thead>
<tr>
<th>Zone</th>
<th>Yes</th>
<th>No</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southeast</td>
<td>13</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Southwest</td>
<td>17</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Lehigh/Capitol</td>
<td>16</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Frequencies were calculated by the author from data drawn from research interviews.

All but one participant responded to the question for each implementation zone. There was less consensus by participants in the Southeast than other zones regarding changes in implementation. As stated by one respondent, “…by going first, going fast, and with no real plan from
the state how to do it, the standard was being set. Changes would be made
down the road based on our experiences.”

There were changes and differences noted however, even in the
Southeast zone, as the program matured. Respondents were asked to identify
what they believed the reasons were for changes in implementation. Many
individuals provided more than one response about why they believe change
occurred. Several provided responses for only one or two of zones, based on
the depth of knowledge they believed they held about the different zones.
Table 5-2 reflects the responses of participants to the question of why
implementation changed among and between zones and indicates how many
participants provided responses in each zone.
Table 5-2: Reasons Provided for Implementation Change\textsuperscript{a}

N=20

<table>
<thead>
<tr>
<th>Reason Provided</th>
<th>Southeast\textsuperscript{b}</th>
<th>Southwest\textsuperscript{c}</th>
<th>Lehigh/Capital\textsuperscript{d}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture of counties causes much of the difference.</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Program more regulated when reaching Lehigh/Capital.</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>State has matured changing implementation expectations.</td>
<td>5</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Counties have learned from each other.</td>
<td>0</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Implementation has become more streamlined over time.</td>
<td>0</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Learned importance of having key players on board at beginning of implementation.</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: Frequencies were calculated by the author from data drawn from research interviews.

a – Multiple responses permitted.
b – 7 participants provided a response for the Southeast zone.
c – 13 participants provided a response for the Southwest zone.
d – 16 participants provided a response for the Lehigh/Capital zone.

Respondents identified different reasons for changes in implementation the longer the policy was in effect. By the time implementation reached the third zone – Lehigh/Capital – more emphasis was placed on the state’s maturation through the process and the development of additional regulations. In keeping with the earlier comment noted about learning from the Southeast zone, respondents further supported...
that through indicating in their responses that “counties were learning from each other.”

The state request for proposal (RFP) is the initial document that guides the contracts established between the state and the counties in each zone. Within the RFP the state established the framework of expectations and, through attached appendices, operational specifics for the contract. Although governed by the same underlying principles and expectations in keeping with the federal waiver to operate the program, the state indicated the streamlining of processes in subsequent RFP releases. The RFP for the Lehigh/Capital region\textsuperscript{10} included appendices with defined regulations that had not been noted in either the Southeast or the Southwest RFP. Additional data collection and submission expectations had been defined, the state was able to readily identify what chapters and sections in existing Pennsylvania statute and regulations could be waived for the program, and they had firmly established that items such as the managed care organization’s (MCO) proposed management information system must be demonstrated as operational before readiness review would be complete.

Perceived Influences Affecting Change

The first research proposition sought information about whether or not perceptions of influence affecting the implementation of behavioral health HealthChoices were consistent across zones. Were, in fact, the same things or the same groups of people what respondents believed influenced differences between programs in each zone? Participants were asked what they believed accounted for differences between policy implementation in each zone. Each individual provided a minimum of one comment for every zone and many offered several. Table 5-3 summarizes those responses.
Table 5-3: Accounting for Difference Between HealthChoices Zones

<table>
<thead>
<tr>
<th>Explanation Offered</th>
<th>Southeast</th>
<th>Southwest</th>
<th>Lehigh/ Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>County driven culture differences.</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Personalities/value systems of county officials.</td>
<td>6</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>What role county officials wanted to play in the system.</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Involvement of advocates.</td>
<td>2</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>How businesses operate; provider capability before HealthChoices.</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Counties joining together to manage one MCO contract.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Ability to use reinvestment dollars.</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>History of prior service system.</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Current financial pressures of the state.</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mercer Consulting very conservative and guided financial processes.</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Frequencies were calculated by the author from data drawn from research interviews. a – Multiple responses permitted.

A greater number of explanations offered for differences among and between zones are clustered in responses related to specific counties (see
Rows 1 – 3 in Table 5-3). Personalities of particular county officials, whether or not the county wanted to hold risk or share it with an MCO partner, and the culture of the county (e.g. fiscally conservative, strength of commissioner/administrator relationships) were all listed by multiple respondents as primary reasons for perceived differences. At the same time there was a greater incidence noted in the Southwest zone of the perceived influence of advocates in creating differences. There, advocates are described by a respondent as “…the most tightly integrated…they have been on board with the managed care organization and county since the beginning of implementation to develop a solid plan.”

**The Role of Advocates**

Advocacy organizations were given a great deal of credit for achieving the behavioral health carve-out during the development of HealthChoices policy (Roche, 1994, 1995). The researcher sought to learn if continued perceptions of participants indicated that advocates – individuals and organizations – continued to shape the program across zones and over time. Questions were asked about what role advocacy organizations and interest groups had in affecting implementation designs and if that varied across zones. Table 5-4 reflects comments of the respondents.
Table 5-4: Perceived Role of Advocacy Organizations/Interest Groups

N = 20

<table>
<thead>
<tr>
<th>Perceived Role</th>
<th>Southeast</th>
<th>Southwest</th>
<th>Lehigh/ Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthChoices viewed successful nationally because of consumer/family involvement.</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Law projects influenced after the fact through lawsuits.</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Ray Webb (provider) well respected and had impact.</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Contracts written to require consumer/family involvement.</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>HealthChoices would not exist with Southeast consumers.</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stronger consumer movement in Southeast.</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Southwest okay, but slow to start.</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Movement almost nonexistent in Lehigh/Capital.</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: Frequencies were calculated by the author from data drawn from research interviews.

- a – Multiple responses permitted.
- b – 13 participants provided a response for the Southeast zone.
- c – 10 participants provided a response for the Southwest zone.
- d – 12 participants provided a response for the Lehigh/Capital zone.

Respondents had previously indicated that they perceived advocates had more influence in the Southwest zone and that this accounted for differences between that region, the Southeast, and Lehigh/Capital. In subsequent responses to additional questions, however, respondents
indicated a greater involvement of advocates and interest groups in the Southeast zone, noting that by the time HealthChoices reached the Lehigh/Capital zone the involvement of advocates and their perceived ability to influence the system was “almost nonexistent.”

When discussing perceptions of advocates and interest groups and their affect on HealthChoices, respondents often linked the involvement in the Southeast with both implementation and achieving the behavioral health carve-out. This may be a direct result of the fact that the carve-out and subsequent implementation of HealthChoices in the Southeast zone occurred very closely together in time. Newspaper accounts of the beginning of implementation in the Southeast generally also referenced the carve-out.\textsuperscript{11,12}

In relation to the Southeast zone respondents noted that HealthChoices would not exist without the involvement of consumers in that zone. In fact, it is reported that Philadelphia officials were not sure that they wanted to participate in HealthChoices on an ongoing basis. Through the perceived influence of vocal advocates a program was initiated and then strengthened.\textsuperscript{13}

\begin{flushright}
\end{flushright}
Responses across all three zones indicate that the expectation that consumers and advocates (though not other related interest group such as the providers and disability law projects) would be involved in the implementation of the program was written directly into the policy. These comments appear to support the proposition that this particular perceived influence – the role of advocates – is similar across regions.

Leadership Changes

In addition to changes attributed by respondents to counties and advocates, the researcher also inquired if there were specific leadership changes during HealthChoices that affected implementation. Although respondents commented regionally by providing responses in context of specific examples they indicated that the changes in leadership affecting the policy were of a statewide nature, if there were any at all. In Table 5-5 particular changes noted by respondents are indicated.
Table 5-5: Leadership Changes Affecting HealthChoices Implementation\textsuperscript{a} 
N = 20

<table>
<thead>
<tr>
<th>Leadership Change Noted</th>
<th>Southeast</th>
<th>Southwest</th>
<th>Lehigh/ Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Charles Curie leaving; new secretary appointed.</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>HealthChoices not the top of anyone’s agenda now.</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Estelle Richman moving from Philadelphia to Harrisburg.</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Consultant layer is gone from the program.</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Policy designed to survive leadership changes.</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

\textit{Source: Frequencies were calculated by the author from data drawn from research interviews.} 
\textit{a – Multiple responses permitted.}

Noted most often was the departure of Charles Curie, Deputy Secretary for the Office of Mental Health and Substance Abuse Services. Mr. Curie was considered by respondents to be the “driving force behind and chief proponent of” the HealthChoices policy. Involved with the Ridge Administration from the outset, Curie kept the development and implementation of the policy at the top of the public welfare agenda. His departure in early 2001 to accept a position in the federal government,
according to respondents, affected HealthChoices statewide because the program lost its “champion.”

That effect, however, was minimized by the structure of the policy itself according to comments. By the time of Curie’s departure HealthChoices had been operational in the Southeast for almost four years and in the Southwest for two. Lehigh/Capital was well into the process of preparation for implementation later that same year. While respondents noted that they expected to see some changes continue as HealthChoices moved forward based on county designs and preferences, the policy itself was robust enough to survive changes in leadership. As well, other individuals with responsibility for state oversight of implementation in the different zones would remain in their positions.

Summary

Information obtained, particularly from structured interview responses, indicates that several perceptions of what and who influenced the implementation of behavioral health in Pennsylvania were consistent across zones. The maturation of the state in policy oversight and expectation; personalities, value systems, and roles of counties in structuring the policy; and leadership changes at the state level during implementation across three zones were referenced by respondents in each area. There were differences,
however, in how respondents viewed the role of advocates and how they believed that subsystem impacted implementation. Though defined as central to the implementation of the policy by state requirement in every implementation, advocates were seen as more influential in the Southeast and Southwest than in Lehigh/Capital.

**Perceived Influences of County and State Governments**

Addressing whether the impact of perceived influence at the county level is greater than that at the state level in creating differences among and between regions was the focus of proposition two. Differences in implementation were noted across zones by respondents as discussed in findings for proposition one, and many of the indications for those differences were attributed to actors at the state and county government levels. As structured interviews progressed, the researcher sought specific information about those differences and to what respondents believed they could be attributed.

Directed specifically at the county level, respondents were asked what influences they felt shaped the distinctions between HealthChoices in counties. Responses are noted in Table 5-6.
Table 5-6: Perceived Influences Shaping Distinctions Between Programs\textsuperscript{a}

N = 20

<table>
<thead>
<tr>
<th>Perceived Influences</th>
<th>Southeast\textsuperscript{b}</th>
<th>Southwest\textsuperscript{c}</th>
<th>Lehigh/Capital\textsuperscript{d}</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO background and experience.</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Making pharmacy part of physical health.</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Previous experience with voluntary managed care.</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Whoever has most political power at implementation.</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>MCO considered a partner or vendor.</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Robustness of the provider network.</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Service usage rates existing prior to HealthChoices.</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>County vision and leadership.</td>
<td>5</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>County priorities in service development.</td>
<td>6</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

\textit{Source: Frequencies were calculated by the author from data drawn from research interviews.}

\textsuperscript{a} – Multiple responses permitted.
\textsuperscript{b} – 16 participants provided a response for the Southeast zone.
\textsuperscript{c} – 14 participants provided a response for the Southwest zone.
\textsuperscript{d} – 13 participants provided a response for the Lehigh/Capital zone.

Participants provided a variety of comments and all indicated at least two responses for what they believed attributed to those differences. In the
Southeast zone respondents indicated that county vision and leadership as well as county priorities in service development were important factors affecting implementation of the program. Individuals spoke of specific actors in the region and plans that county officials wanted to see realized in moving to HealthChoices. As one county administrator stated, “There were areas we expected would grow in HealthChoices because they hadn’t been complete before. We have tried to redirect resources to things behaviorally related but also to support our broader social service agenda. We have piloted school based prevention services because of a commitment in Philadelphia to benefit the greater city structure.”

The Philadelphia Inquirer, in interviews with then Commissioner of Health Estelle Richman and other behavioral health actors in the system, supported statements made by research participants. The author writes that the creation of Community Behavioral Health (CBH) by city government is the first time any city attempted to establish a non-profit corporation to oversee managed behavioral health care for Medicaid-eligible people. Further, the article states, “CBH represents Richman’s dream come true – an integrated mental health system in which the patient comes first and care is not fragmented.”

The Philadelphia HealthChoices program is unique in the fact that it is the only implementation in the state where full control of the program has been retained by the county, a specific desire and design of city officials. CBH is a managed care organization developed and operated by the city. The vision of officials was not to hire another entity to manage Medicaid services for citizens, but rather to incorporate Medicaid-eligible services with similar treatments and services already under county control.\textsuperscript{15}

Other counties in the Southeast zone had different priorities according to participants. For example, in Delaware County respondents stated there was greater concern expressed regarding the financial exposure to the county by implementing HealthChoices. As one individual specified, “A county attorney in Delaware led the move to HealthChoices. Because of that they brought in a national managed care organization who promised them a turn-key approach that would control risk.”

Respondents in the Southwest zone also indicated that county vision and leadership as well as service priorities in the county were perceived as the greatest influence on why implementation of HealthChoices looked as it did. The Southwest zone is geographically twice as large as the Southeast and contains both rural and urban counties. At the outset of HealthChoices the zone also contained two county-joinders, Armstrong/Indiana and

Washington/Greene; counties who had established a joint mental health and mental retardation program prior to HealthChoices. Aside from Allegheny County, which includes the city of Pittsburgh, counties in the region had much smaller populations of Medicaid-eligible recipients.

These factors, among others, were noted as integral components in county decisions regarding how HealthChoices would be implemented. For instance, during the procurement process in the Southwest the Washington/Greene joinder dissolved. “Change is always a big challenge for counties and their commissioners,” stated one respondent. “It’s a wild card that can cause counties to be very conservative. HealthChoices magnifies the problems in a joinder and Greene County is an example. If the local administrator can’t bridge the changes with county commissioners, it can be a problem.” Commissioners in Greene County eventually opted out of the right of first opportunity to implement HealthChoices. County priorities did not include accepting financial risk for Medicaid services.

Allegheny County demanded a very active role for advocates in HealthChoices affecting change in how the policy was implemented. “County leadership is committed to an active stakeholder role in HealthChoices,” commented one respondent. “As a result we have a dynamic advisory structure there that other counties have not permitted. Here I don’t learn anything unless I am hearing it from a consumer or family member.”
By the time implementation began in the Lehigh/Capital zone, county officials had spent four years watching and learning from those in the Southeast and Southwest. With a variety of models in progress, counties could base some of their decisions on the experiences of others. This was evident in the evolution of HealthChoices in Cumberland, Dauphin, Lancaster, Lebanon, and Perry counties. Administrators and commissioners from the five counties joined together to create a territory for the operation of the policy. As part of that decision the counties created a 501(c)3 corporation – The Capital Area Behavioral Health Collaborative, Inc. (CABHC) – “that serves as a management organization to assist the counties in the development, implementation, and administrative management of the HealthChoices behavioral health program.”

The counties also signed an intergovernmental agreement to establish the ability to conduct a single procurement process. They chose to share financial risk as well as create assurances that individuals in each of the five counties could get needed services within the territory. In discussing development of the territory and collaborative one respondent said “The collaborative is responsive and differences in the program here should be attributed to them. CABHC is a one voice answer for counties in the territory.”

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Other counties in the region faced different pressures that drove the development of HealthChoices. York and Adams counties, who function as a joinder, had the highest incidence of behavioral health rehabilitation services (BHRS) in the state. Eighty percent of all mental health expenditures were in this single service as HealthChoices was slated to begin. Officials noted that BHRS, a very costly treatment for children and adolescents, was the driving force behind determining county priorities for York and Adams in HealthChoices. County officials indicated they needed assistance in controlling expenditures and sought a managed care partner to help them do that through HealthChoices implementation. As noted by one, “By implementation we had built such a high level of the service that we had to bring it down because of the cost. One of the things we liked about Community Care was their policies on BHRS – we left it to them to do because we knew they could.”

Perceived Impact of County Structure

Respondents were asked to comment on whether or not they felt the structure of the county – its size, participation in a joinder, or other factors – contributed to the amount of perceived influence they held in HealthChoices implementation. Table 5-7 shows responses of those interviewed.
Table 5-7: County Structure and Impact on Perceived Influence

N = 20

<table>
<thead>
<tr>
<th>Perceived Impact of County Structure</th>
<th>Southeast&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Southwest&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Lehigh/Capital&lt;sup&gt;d&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>County determines what services are included.</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Counties not good business managers.</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Commissioners and efforts to address fiscal issues.</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Smaller counties must band together to form critical mass.</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Counties must review existing relationships.</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Perceived influence comes from leaders not county size.</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Frequencies were calculated by the author from data drawn from research interviews.  
<sup>a</sup> – Multiple responses permitted.  
<sup>b</sup> – 9 participants provided a response for the Southeast zone.  
<sup>c</sup> – 13 participants provided a response for the Southwest zone.  
<sup>d</sup> – 15 participants provided a response for the Lehigh/Capital zone.

Responses to the question varied but there was less indication that county structure was as relevant to the perception of influence as vision and leadership of county officials, as noted in Table 5-6. Three respondents indicated that the structure of the county, in particular its size or joinder status, had no effect of the perception of influence in the Southeast zone. One did, however, believe it had some effect in the Southwest and Lehigh/Capital
as evidenced by the dissolution of joinders and the banding together of counties in Lehigh/Capital to form a territory. By achieving “a critical mass of eligible individuals,” the respondent stated, “the Capital area counties could negotiate their contracts differently.”

Other participants made similar comments in response to implementation in both the Southwest and Lehigh/Capital zones and noted the difficulties of having to do business in that manner. Stated one, “There isn’t any question that sheer numbers change things. The Capital five have 15 county commissioners to deal with and the additional layer of the collaborative. Here it’s just me and my commissioners. It might be more efficient and effective to be larger, but I don’t know if it’s easier.” Another added, “In areas where there is a single county and they are managing themselves they have probably effected the most system change because they are able to see all the different pieces.” In addition, several respondents indicated that it wasn’t the size of the county in any zone, but rather the leaders within the county who were perceived as having more influence, adding further support for previous statements.

Beginning in 1999 in the Southwest zone the state, with the assistance of a federal grant, began publishing early warning reports designed to test a limited set of indicators that would allow for early detection of
implementation problems. These reports were then expanded to include the Southeast in 2000 and Lehigh/Capital beginning with implementation in 2001. While the reports focus on providing data regarding specific activities within HealthChoices, the presentation of the information can also be viewed in light of the question of county size. Data are reported in two ways – by individual county and then in aggregate form based on the partnership of the county with the managed care organization (MCO). For example, in the Southwest zone nine of the 10 counties had a relationship with Value Behavioral Health of Pennsylvania. Allegheny County had partnered with Community Care Behavioral Health. When reporting information on such things as treatment authorizations and complaints and grievances, the early warning reports present information by MCO for comparison, rather than only by county. This change appears to minimize specific trends that may be occurring in particular county programs and shifts the focus of the state to the actions of the managed care companies with larger population groups. The report also included responses from actors in the zone to data presented. These responses are also provided by the MCO rather than the individual county.

Individuals and Groups Impacting Policy Development

Respondents were asked to identify who they believed had the greatest impact on the development of policy and regulations guiding the program. In light of other data, the researcher expected participants to indicate a variety of groups and individual actors across all subsystems. Instead, respondents commented as noted in Table 5-8. In retrospect, the placement of the question in the interview structure (near the beginning following discussion of the carve-out and prior to specific questions related to any subsystem), may account for some of narrowness of response.
Table 5-8: Individuals/Groups Impacting Policy/Regulatory Development

N = 20

<table>
<thead>
<tr>
<th>Individuals/Groups Identified</th>
<th>Southeast(^b)</th>
<th>Southwest(^c)</th>
<th>Lehigh/Capital(^d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Government</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>State Government</td>
<td>5</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Mercer Consulting</td>
<td>6</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Consumers/Families</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Joan Erney (State Government)</td>
<td>5</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Charles Curie (State Government)</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feather Houstoun (State Government)</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Linda Zelch (State Government)</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Terry Mardis (State Government)</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Jerry Kopelman (State Government)</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: Frequencies were calculated by the author from data drawn from research interviews.  
\(^a\) Multiple responses permitted.  
\(^b\) 14 participants provided a response for the Southeast zone.  
\(^c\) 10 participants provided a response for the Southwest zone.  
\(^d\) 8 participants provided a response for the Lehigh/Capital zone.

One participant indicated that the federal government had the greatest impact on the overall policy because it was the federal government’s determination that the waiver request was acceptable that allowed Pennsylvania to move forward with the policy. Two individuals noted that
consumers and families (though they did not specify individuals) had great impact. Six included Mercer Consulting, which worked directly with the commonwealth, as having great impact on the program because of their ability to assist with actuarial data. The remainder of all responses, however, were either names of specific individuals who worked for state government or a general reference to the state as having the most impact. As also indicated in Table 5-8, there was a greater incidence of responses in the Southeast than in the Southwest or Lehigh/Capital. The researcher feels this is indicative of two things. First, it supports other comments that many of the particulars of the policy were established by the state and were refined as time progressed as noted in Table 5-2. Second, although the Department of Public Welfare stated from the outset of implementation in 1997 that they intended to move to HealthChoices in the three zones, there was less immediate concern by actors in areas outside of the Southeast to closely follow initial activities. While they waited for HealthChoices to reach other areas they remained responsible for assuring the behavioral health services as currently funded continued.

Near the close of the structured interview, following questions related to each of the subsystems and how implementation occurred in specific regions, respondents were asked to identify which subsystem they perceived had the greatest influence on the models of implementation undertaken. Their comments are noted in Table 5-9.
Table 5-9: Subsystem With Greatest Perceived Influence on Implementation N = 20

<table>
<thead>
<tr>
<th>Identified Subsystem</th>
<th>Number Responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>State; control funding.</td>
<td>2</td>
</tr>
<tr>
<td>State; outlined program parameters.</td>
<td>6</td>
</tr>
<tr>
<td>Counties; first right of opportunity.</td>
<td>10</td>
</tr>
<tr>
<td>Advocates.</td>
<td>2</td>
</tr>
</tbody>
</table>

*Source: Frequencies were calculated by the author from data drawn from research interviews.*

Participants did not provide comments based on zone. Each instead spoke of HealthChoices in Pennsylvania as a whole. As shown in Table 5-9 the comments of participants were almost evenly divided between state and county government although two state officials did indicate that the greatest influence came from advocates. There was no mention of managed care organizations or providers and other interest groups as those perceived as holding the most influence in the implementation models.

**Summary**

The data reflect that when speaking of regional implementation, respondents were more likely to perceive counties as having more influence than the state in determining how the policy would look in a specific zone. However, when asked to specify particular individuals who impacted
implementation of the policy, none of the respondents noted any county-level
government officials. This shows that when participants did not limit their
responses to a particular zone they were almost evenly divided on perceptions
of who had the greatest influence – eight selected state government and 10
selected county government. Document reviews supplement the mixed
responses. As cited previously in this section, articles and reports note the
relationships between state and county governments in the implementation
of HealthChoices, at times giving more emphasis to county and advocate
actors than to state actors and at other times referencing planning and
decisions made at the state level in policy development as determining
factors in the structure of the implementation models.

The Impact of County/MCO Relationships

The final proposition sought information about the relationships
between county governments and their managed care partners and whether
or not these relationships had any perceived impact on the implementation of
the policy in a specific region. Counties were given three implementation
options by the state: (1) assume full financial risk for HealthChoices and
implement the policy themselves, (2) assume financial risk for HealthChoices
and share that risk with a subcontracted managed care organization (MCO);
or (3) refuse the right of first opportunity and the assumption of risk and allow the state to operate HealthChoices in their county.

The selection of the MCO partner by counties occurred through a request for proposal (RFP) process similar to the one enacted between the state and county. With knowledge of coming state expectations for HealthChoices, individual counties or county groups issued their own RFP, seeking a MCO to assist in the policy implementation. In these RFPs counties stated their requirements for an MCO partner including financial, clinical, administrative, information systems, and claims payment responsibilities. The RFPs also included requirements for supplemental services and outlined the governance structure the county(ies) planned to impose on the implementation of policy. In soliciting responses to the RFP counties were able to delineate what type of relationship they wished to have with an MCO. For example, in the five-county territory in Lehigh/Capital county officials, through their oversight management company, outlined their expectations for participation on internal MCO committees and their expectations of the MCO to work with a selected outside auditor for claims payment.18 Although they wanted the MCO to complete the actual tasks outlined, they did expect

to be very involved in the day-to-day workings of the program. A great deal of
emphasis was placed on the relationship the counties expected to establish
with the selected MCO.\textsuperscript{19}

Respondents were asked what they believed the impact was regarding
the relationship between counties and MCOs. They were also asked to
describe whether or not they felt this affected the level of perceived influence
the counties had in implementing their particular HealthChoices program
and why. Table \textit{5-10} provides a summary of comments by participants.

\textsuperscript{19} Ibid.
Table 5-10: Perceived Impact of MCO Structure

<table>
<thead>
<tr>
<th>Perceived Impact of MCO Structure</th>
<th>Southeast(^b)</th>
<th>Southwest(^c)</th>
<th>Lehigh/Capital(^d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Magellan interested only in the bottom line.</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Home grown companies more successful.</td>
<td>2</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Not the structure, but where risk lies.</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Personal relationships with MCO officials more important than structure.</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Frequencies were calculated by the author from data drawn from research interviews.  
\(a\) – Multiple responses permitted.  
\(b\) – 12 participants provided a response for the Southeast zone.  
\(c\) – 13 participants provided a response for the Southwest zone.  
\(d\) – 13 participants provided a response for the Lehigh/Capital zone.

Four individuals noted that they did not feel that MCO – its size, national or local origin, or profit status – had any affect on the ability of the county to influence the implementation of their program. Noted one, “...managed care organizations come and go, but the county stays.” Other respondents stated that it was not the characteristics of the MCO that changed the ability of the county to provide influence, but rather were the relationships between county and MCO officials. “…[C]ounty officials tend to be those that haven’t come up through the system,” said one interest group.
respondent. “When you have an MCO like Community Care with a long-term, well respected former provider at the helm backed by a university and research institute those relationships become very powerful. When people are seen as invested in the system, not simply a single company, it drives change.” Tied into that, others indicated, is where the risk for the policy lies. “The county makes the determination of the kind of partner they are looking for and the kind of risk they want to hold or share,” stated one. “The county has the influence by what company they select.”

Respondents divided the MCOs operating in HealthChoices into two categories – national companies and “home grown” organizations. National companies such as Magellan Behavioral Health and Value Behavioral Health of Pennsylvania were not often viewed as partners with counties. Instead, respondents indicated that those organizations are responsive to stockholders and larger corporations and that this drives their determination to behave differently. “I have to fight with them every day,” stated one participant, “and that affects my time and ability to address larger issues with the state to change the program.” Added another, “Magellan is interested only in the bottom line. By focusing on just one aspect of what HealthChoices is supposed to be, we lose our ability to be comprehensive and change our system.”

Home grown companies as defined by interview respondents are those MCOs that began operations in direct response to HealthChoices. This
includes Community Behavioral Health, Community Care Behavioral Health, and Community Behavioral HealthCare Network of Pennsylvania. Though different in ownership structures, all three companies were created to assist in managing HealthChoices-specific contracts. Because of their investment in the Pennsylvania public sector, respondents believe relationships between counties and those MCOs allow them greater latitude in program implementation, especially in the Southwest and Lehigh/Capital zones.

“Organizations that come from the community are treated better by the state than those who do not,” commented one respondent. “The perception is that when they make suggestions about changing the policy it is because they understand the needs of people being treated.” Added another, “Being local gives a certain advantage because the assumption is that you know the county, the needs, the resources, and the existing relationships.” As well, added a third, “National companies just don’t get it in terms of the public sector population and that’s a real problem. As programs roll out and have some success counties start to not trust their national partners as much and that is displayed to the state. All the changes that have occurred in county-MCO relationships to date have all been with national groups.”

References were made to one county/MCO relationship that altered the HealthChoices program as defined by the state to a large extent – the relationship between Philadelphia County and Community Behavioral
Health (CBH). Respondents were quick to point out, however, that this difference needed to be seen in context. “Philadelphia County is CBH and CBH is Philadelphia County. They are also the largest single program and they went first. Who knows how much impact that really had on what they were allowed to do that others have not been?” Others indicated that there was not enough understanding, even by state officials who had crafted the policy, of what they might expect and if the program could truly be implemented as originally developed. Stated one, “In Philadelphia the carve-out and subsequent HealthChoices implementation was very rapid and chaotic. Estelle [Richman, county commissioner] is famous for stating ‘let the wave overtake me.’ Many lessons were learned…it wasn’t until we completed implementation in all three zones that we at the state level finally think we know how it should be done.”

Summary

Twenty percent (N = 4) stated that the particular managed care organization did not have any impact on the ability of the counties to create additional changes in HealthChoices implementation; e.g. there was no perception of increased influence based on those relationships. Of those respondents that feel there was some effect, these changes were attributable primarily to MCOs that had been created specifically to work within the
HealthChoices arena. In addition, counties made upfront determinations about the kind of MCO partner they were seeking through their own procurement processes. Those seeking relationships where they expected the MCO to partner with them in managing the policy indicated such in their RFPs, as did those who were seeking more of a vendor relationship. There were comments that Pennsylvania-only MCOs provided the county more ability to create variance from the state model because it was believed they understood the larger state system and were committed to working within it, rather than being responsive to stockholders or other larger corporations outside of Pennsylvania. And finally, participants wondered about how the ability to affect policy change was affected by when HealthChoices arrived at the county, asking the broader question of whether “going first” accounted for more of the difference than the relationship between the county and MCO.

**Discussion**

Although the data are primarily perceptual in nature, responses from interview participants and supporting information gleaned from historical documents appear to indicate that some changes in Pennsylvania behavioral health policy can be attributed to the involvement of individuals in the local (county or regional) environment. The majority of interviewees perceive differences among and between zones in implementation of HealthChoices.
Initially they accounted for those differences in two ways – counties were able to learn from each other as implementation progressed over time and the state program matured over time, becoming more defined and streamlined in relation to regulations and expectations of the commonwealth.

In discussing whether or not the same influences were perceived among and between zones to account for differences in implementation models, respondents generally believe that similar actions and personalities have an effect across zones. The personalities, value systems, and roles of counties in structuring the policy, including the nature of the county and how it had undertaken behavioral health responsibilities prior to HealthChoices were referenced by respondents in all three zones. Respondents indicated that changes in state leadership affected all zones. Although the state policy was crafted to withstand leadership changes, the impact of a change – particularly at the deputy secretary level – was felt across all zones.

Differences were noted, however, in the role of advocates – particularly consumers – and how that subsystem impacted implementation. Advocates were viewed as more influential in the Southeast and Southwest zones. Historical documents also reflect a greater involvement of advocates in those regions, most notably the Southeast. It is unclear, however, why participants think this occurred. Was the increased involvement a result of the Southeast implementation following closely on the heels of the behavioral health carve-out that had an even higher level of advocate/consumer involvement? Was
the greater involvement simply a reflection of the fact that the consumer and advocacy movements in Pennsylvania are centered in the large urban cities of Philadelphia and Pittsburgh? This study did not obtain the depth of information necessary to answer those questions, but the topic should be considered in some detail prior to making definitive statements about the role of advocates in HealthChoices implementation.

When discussing the HealthChoices policy by zone, respondents frequently indicated that they believed county officials had more influence than state officials in determining how the policy would look in their specific zone. Instances were cited of specific differences in county models determined by what supplemental services officials included in their plans. This was supported through a review of documents outlining expectations of counties for their program. Because of those comments, the researcher expected that when respondents were asked to identify by name particular individuals who they perceived had greater influence in the implementation of the model a variety of people would be mentioned including county officials, well-known advocates, and consultants working with county governments in different regions. Instead, particular individuals named by respondents all represented state government. It might be that the order of questioning during the interview affected responses to this question. Beginning interview questions focused on the behavioral health carve-out and the early planning that led to the creation of HealthChoices in Pennsylvania, including the role
of the federal government in approving the waiver. The question of individuals with particular influence followed shortly after this discussion and prior to asking respondents to comment about specific zones and/or individual subsystems. The responses may be more reflective of the carve-out discussion and original state policy than how the policy was subsequently implemented in any specific zone.

When respondents did not limit comments about perceived influence to the regional level, they were almost evenly divided regarding which subsystem they felt had the greatest influence in HealthChoices implementation. Eight respondents indicated that they perceived state government as the most influential, either because they controlled funding for the program or because they had set the broad parameters within which local programs must operate. Ten respondents indicated that they perceived counties as the most influential. They indicated that the county right of first opportunity to manage the program as it best met local needs was the most important factor in determining differences between programs. Historical documents also address the division of responses given by participants. Articles and reports at times give more emphasis to county and advocate actors than to state actors and at other times reference planning and decisions made at the state level in policy development as determining factors in implementation models.
Based on the description of difficult experiences that advocates, consumers, providers, and counties had with voluntary managed care organizations prior to carve-out and the implementation of HealthChoices (Collins, 1995, 1996; Flannery, 1994, 1995; Roche, 1994, 1995), the researcher included a proposition addressing whether the relationship between counties and MCOs had any perceived impact on the implementation of the program. Specifically, if the MCO was considered by the county as more of a “partner” in program implementation than a vendor simply hired to complete specific tasks such as service authorizations and claims payment, would respondents perceive that the relationship provided greater ability to change the implementation of the policy as originally crafted by the state? Of the 20 interview participants, four stated that the managed care organization had no impact on implementation of HealthChoices in a particular county or zone. Of those responding who did believe there was some effect, comments attributed much of the changes to MCOs that had been developed specifically to work within HealthChoices, naming three of the five companies currently operating in Pennsylvania.

Participants did note, however, that it was not clear if it was the MCO and specific individuals within the organization or the earlier determination by the counties as to what kind of relationship they were seeking with a managed care partner that was the primary contributor to any perceived variance from the state model that might be noted. There were comments
that respondents perceived that state government officials gave more latitude to the Pennsylvania-specific MCOs (and subsequently the counties they partnered with) because it was believed they understood the larger state system and were committed to working within it, rather than being responsive to stockholders or other larger corporations outside of the state.

**Summary**

HealthChoices implementation occurred across a period of several years. During that time shifts in state leadership, the health of the state and national economy, and the maturation of the policy all occurred. The exploratory nature of this research renders this study unable to address those issues and the impact they might have on the ability of actors to be perceived as influential in policy implementation. However, perceptions of how individuals and groups of actors influence public behavioral health at the county and state levels of government in Pennsylvania are available. Participants in this study express great depth and breadth of knowledge about the policy arena. Their comments addressing the specific research question provide a nucleus for additional questions to explore around the issue of influence in policy implementation, as will be discussed in Chapter Six.
Chapter 6

Conclusions

The study addressed how the perceived influence of particular actors and/or groups affects the implementation of public policy. Stated more specifically the research question becomes, “Is regional implementation of behavioral health policy in Pennsylvania changed by the involvement and/or influence of officials, bureaucrats, and other actors in the policy environment?” Data were gathered primarily through structured interviews with individuals involved in the Pennsylvania public behavioral health system. Their responses were supplemented by the review of historical documents related to that same system. A series of exploratory propositions were set forth to examine the research question and generate ideas for further study. Those propositions are:

- Perceptions of influences that affect the implementation of behavioral health in Pennsylvania are consistent across regions that have implemented the Medicaid managed care program, HealthChoices.
- The perceived impact of influence at the county government level is greater than the impact of perceived influence of the state
bureaucracy in program implementation, creating differences in the HealthChoices program across regions.

- A collaborative relationship between county government and the contracted managed care organization increases variance in implementation from the HealthChoices program as defined by the state.

The research was a limited single-state case study, designed as an exploratory study to provide additional information about relationships and actions that affect the implementation of a public policy. Pennsylvania HealthChoices has been implemented in three zones – Southeast, Southwest, and Lehigh/Capital – defined by geographical county borders. Within each zone more than one HealthChoices program is operational.

Data were gathered at the regional level in an effort to gain more comprehensive information about how implementation occurred. Additionally, information was sought about each of the five subsystems in the public behavioral health arena. The researcher developed open-ended questions for structured interviews. Questions were designed to (a) provide additional support or refute background information already collected, (b) gain information specific to each proposition, and (c) to determine if there were other factors aside from the perceived influence of individuals or groups of actors that respondents believed might affect any differences noted among and between HealthChoices zones.
Summary of Findings

Data addressing proposition one, particularly from structured interview responses, indicate that several perceptions of what and who influenced the implementation of behavioral health in Pennsylvania are consistent across zones. The maturation of the state in policy oversight and expectation; personalities, value systems, and roles of counties in structuring the policy; and leadership changes at the state level during implementation across three regions were referenced by respondents in each region. There are differences, however, in how respondents view the role of advocates and how they believe that subsystem impacts implementation. Though defined as central to the implementation of the policy by state requirement in every implementation, advocates are seen as more influential in the Southeast and Southwest zones than in Lehigh/Capital. This was attributed primarily to the timing of HealthChoices in the Southeast closely following the carve-out and to the maturation of the policy by the time of implementation in Lehigh/Capital, making it more difficult for advocates to impact change.

In addressing proposition two regarding the impact of perceived influence at the county and state government levels, data reflect that when speaking of regional implementation, respondents are more likely to indicate that they perceive counties as having more influence than the state in determining how the policy looks in their specific area. However, when asked
to specify particular individuals who influence policy implementation, none of
the respondents mentioned any county-level government officials. Those data
further reflect that when participants do not constrain their responses to a
particular zone they are almost evenly divided in who they perceive has the
greatest influence – eight selected state government and 10 selected county
government.

Document reviews also help explain these mixed responses. Articles
and reports note the relationships between state and county governments in
the implementation of HealthChoices, at times giving more emphasis to
county and advocate actors than to state actors and at other times
referencing planning and decisions made at the state level in policy
development as determining factors in the structure of the implementation
models. For example, data are presented in state early warning reports by
both individual county and in aggregate form by the managed care
organization serving the county. When the reports are focused at the county-
level more emphasis is placed on particular differences among and between
individual counties. When data are presented by MCO, issues are addressed
on the broader, regional scale.

The third proposition explored relationships between county
government and managed care organizations (MCOs) and whether these
relationships have any effect on the counties’ ability to influence
implementation. Twenty percent of respondents stated that the particular
MCO did not have any impact; there is no perception of increased influence based on those relationships. Those respondents that believe there was some effect indicate the changes are attributed primarily to MCOs that had been created specifically to work within HealthChoices. Counties are perceived as making initial determinations about the kinds of MCO partners wanted through their own procurement processes. There were comments that Pennsylvania-only MCOs provided the county more ability to create variance from the state model because it was believed they understood the larger state system and were committed to working within it, rather than being responsive to stockholders or other larger corporations outside of Pennsylvania. And finally, participants speculated about how the ability to affect policy change was affected by when HealthChoices arrived at the county. They asked the broader question of whether “going first” accounted for more of the difference than the relationship between the county and MCO.

**Relationships to Prior Research**

It is difficult to draw conclusions about how influence demonstrated by various subsystems in a policy domain affect the implementation of a public policy. This exploratory study, however, adds to future discussion of individual and group influence in implementation. Study participants perceive that there are notable differences in implementation when discretion
is provided to different levels of government. As Lane (1995) noted, concepts, models, and approaches to public sector policy continue to evolve and are focused, in part, on strategies and tactics employed by actors in the process. These actions, used in attempts to exert influence, are seen in this research.

For example, the achievement of a carve-out of behavioral health in HealthChoices is considered as central to the future ability of county government to have a high level of influence on program implementation. Individuals in the identified subsystems used similar strategies to assist in making the carve-out reality in the commonwealth. Without the county right of first opportunity inherent in the carve-out, the Pennsylvania Medicaid program would have been much more likely to look the same across the commonwealth, with little ability for local implementation to reflect the unique needs of citizens. By assuring that the county government could, with some constraints, establish program parameters that took advantage of county strengths, implementation would be subject to some variance based on how much influence county government tried to exert to alter the state program to meet specific needs. Initial attempts of counties to tailor implementation to meet local needs was seen in the counties requests for proposals (RFPs).

At the same time, by engaging in a roll-out process rather than attempting a statewide implementation, the Ridge Administration supported an evolutionary policy process, as described by Bardach (1977) and
Wildavsky (1984). When framed as a learning model or model of evolution, policy implementation is endless. Each step in the process results in a determination of outcomes, which in turn changes objectives. This is demonstrated in “lessons learned” as the HealthChoices program moved from zone to zone. After implementation was underway in the Southwest, the state began the early warning monitoring process. Designed to assure that specific targets of service access were being met, the early warning study focused on how particular implementation models were achieving those goals. Due to the impact of that process and the ability to more closely monitor areas of concern in the Southwest, the state determined that the Southeast zone – which had begun implementation two years earlier – needed to be included in the study. By doing so, implementation models in the Southwest affected expectations of what the Southeast counties could do as well.

State officials were not averse to changing expectations of the original program standards and requirements as they gained more experience in the implementation of this policy. Issues that had arisen in the Southeast implementation and solutions to address them were incorporated into expectations of the Southwest zone and further refined in the roll-out of the Lehigh/Capital zone. By doing so, state officials maintained influence in implementation of the program as well as supported the learning model of policy development.
Elmore (1978) and Lipsky (1978) addressed how the involvement of more individuals would change implementation theory. They indicated that more attention should be focused on those responsible for the day-to-day implementation of policy. This research appears to support their statement about the involvement of many affecting implementation. In contrast to states such as Tennessee and Massachusetts, which retained all of the control for Medicaid behavioral health at the state level, the involvement of county government and its managed care partners is perceived to have a local impact on how the state program was implemented in different zones. By providing standards and guidelines within which local groups can offer alternatives, the HealthChoices program is able to more readily reflect the interests and needs of local communities.

At the same time, because of the shift in the state offices from staff being responsible for day-to-day operation of the Medicaid behavioral health policy to being responsible for oversight of larger program goals, the role of those officials also evolved. Work responsibilities of employees were realigned, new bureaus were developed, and new actors became involved in the implementation of public health policy. These changes that began during the Southeast region implementation have continued. Regional Department of Public Welfare offices, rather than retaining all of the autonomy they once had for oversight of all services in their geographic area, are now more responsible to central bureaus in the state capital. Direction of what tasks
should be accomplished, what portions of the program would be monitored and how they would be monitored, and the interpretation of regulation became more centralized at the state level while regional office staff had less ability to interpret and negotiate regulatory requirements. That responsibility had been given to the counties when they accepted the opportunity to run their own programs.

The changing role of interest groups as noted in the literature (Nownes & Freeman, 1998; Loomis & Cigler, 2002) is also reflected in the HealthChoices implementation. Traditionally, legislatures have been seen as the primary target of interest group influence. However, more recently groups have indicated their intent and efforts have focused on shaping influence at the administrative level. That was most clearly seen by the actions undertaken to secure the carve-out. Rather than focus solely on the legislature to impact how and where behavioral health services would be delivered in HealthChoices, providers, advocates, counties, and state bureaucrats focused their attention on key actors in the Ridge Administration. At the same time their opponents, the large health maintenance organizations who had been covering all services in the voluntary program, focused much of their attention on the legislature to prevent the carve-out.

The interest group literature notes that state and local level governments also operate as interest groups, lobbying each other and the
federal government for change (Cammisa, 1995). Again, this research appears to support those findings. HealthChoices contracts in each zone are made between the state and the county (or group of counties). By responding to the state RFP, each county had the opportunity to include new and different ideas in their implementation model. They were, in effect, lobbying the state for variance in the policy. As well, program rates (the amount of funding per member, per month available to operate HealthChoices) are negotiated between those two levels of government. Further, the demonstration by Pennsylvania of seeking a Medicaid waiver to operate a mandatory managed care program was the commonwealth’s effort to apply pressure on the federal government to change the structure of Medicaid in the state. Freedom from some of the regulations would allow the state to, as they noted in their waiver request, decrease inefficiencies in the program and contain costs.

Finally, O’Toole (2000) notes that opportunities for influence between governmental actors increase as changes occur in the public health arena. This study appears to support this statement as well. Where implementation power for Medicaid was once perceived as totally in the hands of state government – from regulation to licensure to payment for services delivered – HealthChoices brought new avenues to explore by county administrations. The pivotal role played by state agencies in shaping and in implementing Medicaid policy remained (Devers, 1997 and Weissert, 2003), though altered
in focus. Rather than prescribing each detail of how a program would operate, HealthChoices allowed counties to select one of three options to implement their program. While retaining a primary role in dictating the broad parameters of the policy the state also allowed a significant portion of implementation decisions to be in county control. This also lends support to Schneider’s (1988) work on how intergovernmental relationships improve access and quality of care for vulnerable populations.

Anton (1997) notes that transferring more responsibility from state to county government for Medicaid implementation results in the need to devise mechanisms for holding lower-level governments accountable for the use of federal and state dollars. The data, both comments from interview respondents and historical documents, indicate that the state continues to provide high levels of monitoring to assure that the different implementations in counties maintain the standards devised by the state and approved by the federal government. As long as the process of devolution and shared responsibility continues national, state, and county government will likely remain in relationship with one another.

**Answering the Research Question**

Kettl (1996) states that “one of the best reasons to do empirical work in public administration, in fact, is not because of the answers it produces but
because of the questions it defines.” This study sought information about whether or not the perceived influence of actors in local policy environments would change implementation of health policy. Because of the limited scope of the study – both in its constraint to one state and limits in numbers of participants – a definitive answer to the question cannot be achieved. However, study findings do seem to indicate that some changes are noted due to the ability of local government to implement and manage day-to-day operations in ways they feel best address regional issues.

Findings also seem to suggest that the “fundamental management dilemma of micromanagement” as described by Behn (1995), though continuing, is being addressed through policies such as HealthChoices. In framing the micromanagement question as one of distrust between levels of government as well as distrust among and between public agencies, Behn suggests that the cyclical issues of distrust beget more and more procedural rules. While it is clear that HealthChoices still includes a wealth of procedural rules and processes dictated by state government and supported through oversight by the federal government, there have been attempts to increase levels of trust among and between governmental levels. By allowing the first right of opportunity to counties, followed by the county’s ability to complete their own procurement process for a managed care partner, the state released much of the control of day-to-day activities.
As was noted in the findings, however, the levels of trust may not be the same in each zone or county. As one respondent commented in discussion of the perceived impact of the MCOs, “organizations that come from the community are treated better by the state than those who do not.” She went on to imply a greater level of trust in those organizations because they are perceived to “understand the needs of people being treated.”

This study also outlines many new questions that can be considered in attempting to not only answer the questions of influence in regional policy implementation, but also the broader questions of management by public bureaucracies. For example, although the state created three implementation zones – Southeast, Southwest, and Lehigh/Capital – there exist within those geographical areas a number of individual implementations of the policy. Even as trending and evaluation reports have focused to date on the zones, there may be a need to look at specific implementation efforts within the zone (i.e. specific models in Philadelphia, Montgomery, Bucks, Chester, and Delaware counties in the Southeast). A greater understanding of the ability of individual actors to influence implementation might become apparent by comparing the actions and activities of specific actors within a zone, e.g. the county commissioners’ decision regarding accepting risk or the county mental health administrators charged with day-to-day operations of HealthChoices. A comparison of actors within a particular subsystem, focused more on their activities in the process of implementation, may shed more light on how
relationships between state and local officials affect the implementation of policy.

Research findings also express differences in which subsystem is perceived to have the most influence in implementation of HealthChoices. When asked to comment on what causes changes among and between regions, participants provided a variety of responses, attributing much of the change to the leadership, vision, and priorities of the county. But when asked to specifically name individuals who they perceived as influential in HealthChoices respondents restricted their responses to identifying state government and state officials. Further, when they responded without reference to a specific zone, participants were almost evenly divided in believing that county and state government held the most influence in implementation. Those findings suggest that perhaps the subsystems identified in this research may be too broad to obtain information about how influence affects the management of public policy and, perhaps, greater attention should be paid to specific individuals, the length of time they have been involved in the policy arena, whether they are political appointees or career bureaucrats, etc.

Discussion with participants has also led to new questions that may have great impact on the ability of individuals to influence the implementation of a policy such as HealthChoices. How do perceptions of influence change when there is a change in state administration? Are their
differences when the new administration is of the opposite political party than the one that initiated the policy? When implementation efforts take place over the course of many years what other external factors – such as a dwindling or booming economy – affect the ability of different groups to have influence? For example and specific to this study, “Would HealthChoices in Lehigh/Capital look different if the economy had not changed so dramatically following the events of September 11, 2001? Would there have been more resources to ensure that all of the new initiatives of the counties could be implemented as they had been in the Southeast? Is that, in fact, why they weren’t?”

**Suggestions for Further Research**

The questions above could all serve as focal points for future research. Each could further the exploration of influence among and between actors and subsystems implementing public policy. As HealthChoices moves forward in Pennsylvania’s Northeast region in 2006, opportunities may exist to build on the current findings through observation of an implementation as it occurs, rather than relying on historical review.

Perhaps more importantly, however, would be an effort to study the implementation models of public behavioral health in other states that have programs similar to Pennsylvania – operational control has been provided to
local governments while state government provides oversight and monitoring. A similar model exists in the Michigan Medicaid behavioral health program. In 1997 Michigan, like Pennsylvania, carved out behavioral health resources from physical health. They then established contracts with 46 Community Mental Health Services Programs who, like Pennsylvania county governments, already had statutory entitlement to operate identical state-funded programs. A study of the relationships between local and state entities in Michigan in comparison to the same relationships in Pennsylvania would offer further insight into the role of perceived influence in subsystem relationships. As well, it could also enhance the public management discussions of micromanagement, motivation, and measurement.

Much of the documented information on this topic in Pennsylvania and Michigan as well as other states is currently reflected in single-state case studies. With rising pressure and recent actions taken at the federal level to constrain Medicaid costs to better manage the federal budget\textsuperscript{20} there is even more need to know how state programs operate and which ones are considered successful in containing costs while still providing needed services. And, as those “successful” state programs are identified, understanding how particular individuals and/or interest groups impact the models so they can be replicated elsewhere in the country will be critical to

\textsuperscript{20} FamiliesUSA. (2005, November 18). \textit{House adopts budget reconciliation bill that will harm Medicaid enrollees}. Washington, DC.
assuring that citizens in need of treatment can receive well-planned, necessary care.
Bibliography


Appendix A

Interview Questions

1. Describe your involvement in the Pennsylvania public behavioral health care program, HealthChoices. (zones, positions, length of time, etc.)

2. Pennsylvania’s carve out of behavioral health dollars from Medicaid physical health is referred to as a pivotal decision point in the development of the HealthChoices program. What opportunities did that provide?

3. What problems or difficulties did it create?

4. Who do you believe were key players in the determination of carve-out and what impact did they have?

5. When Pennsylvania first announced its move to Medicaid managed care through the HealthChoices waiver, what changes did you expect to see?
6. Did those changes occur? Immediately or over time? Were those changes a result of particular individuals involved in the development of the program?

7. How did you feel the Pennsylvania model compared to other state initiatives that had already been implemented? Do you feel Pennsylvania built the HealthChoices model on “lessons learned” from other states?

8. The process of developing the regulations/policies guiding HealthChoices was lengthy. Was that a public process or limited to selected participants? Were you involved?

9. Do you believe the implementation of HealthChoices has changed over time (zone to zone)? How and why/why not?

10. Who were the people that had the greatest impact on the shaping of those policies and regulations? Why?

11. There are differences in how HealthChoices “looks” between and within implementation zones. What do you think accounts for those differences?
12. Have there been leadership changes during HealthChoices implementation that have effected program change? Please provide examples.

13. What influences shape the distinctions between HealthChoices programs in various counties (e.g. what services to include, practice patterns, etc.)?

14. Do you think as a result of implementation across three zones that program changes have occurred at the state level? What has changed? How will that impact future implementation?

15. Does the MCO structure (local/national, for profit/non-profit, age/experience) have any impact on the level of influence exhibited by county officials in local implementation? How and why?

16. Does the county structure (single/joinder/territory, leadership experience) have any impact on the level of influence exhibited by county officials in local implementation? How and why?
17. What factors outside of the direct interactions among and between state officials, county officials, and MCOs has affected implementation of HealthChoices?

18. Have any of these factors had more influence on the program than others?

19. What role have advocacy organizations and other interest groups had in affecting the implementation designs of HealthChoices?

20. Has that varied across regions? How?

21. Do those interest groups provide more impact locally or statewide?

22. Who has the greatest influence on the implementation model in a specific zone – the state, the county, or others?

23. What other information do you believe is pertinent to understanding how influence affects HealthChoices implementation?

24. Who else do you believe should be interviewed for this research?
Appendix B

Letter of Invitation to Participate in Research Study

Date

Participant Name
Affiliation
Street Address
City, State, ZIP

Dear Name:

As a Penn State University doctoral candidate in public administration I am writing to ask your consideration to be an interview subject for my dissertation research. The project, *The Role of Influence in Public Policy: Pennsylvania HealthChoices – A Case Study*, is designed to address how the influence of particular actors and groups affects the implementation of public policy. In particular, this research focuses on the Pennsylvania behavioral health Medicaid managed care program, HealthChoices. Influence, as defined for this research, is the ability of an individual or group to affect the course of HealthChoices implementation through specialized knowledge, personal relationships with key actors, and the regulatory requirement of local control over policy.
As you are aware, United States health policy is very complex – especially in the public arena – with multiple variables and many layers of government responsible for the implementation of those policies. By focusing on one aspect of implementation I hope to add data to the knowledge base for future research on the implementation of other large public programs. I selected behavioral HealthChoices for the focus of my research for two reasons: (1) my familiarity with the program and many of the people involved in the design and implementation of the policy through past and current relationships and (2) because by selecting a smaller portion of the entire HealthChoices program – the behavioral health component – I believe I have opportunity to collect meaningful data that will enhance the field.

Your participation would be through consent to a structured interview with me regarding your opinions, perceptions, and recollections of the HealthChoices implementation process in Pennsylvania since 1996. I have sought your participation because of your past and current affiliations with entities integral to the program. I am requesting representatives from several subsystems to participate in the interview process: state government officials; county government officials; managed care administrators and executives; providers, advocates, and consumers; and representatives of other related interest groups such as behavioral health associations. Information you provide in the interview process will remain confidential. The only persons who would be able to identify your responses will be me and my
faculty advisor at the university. In addition to structured interviews, I hope to corroborate perceptual data through documentation and public records about the implementation process. In addition to primary documents such as requests for proposals and published annual reports about HealthChoices, I intend to do an historical review of newspaper archives from the implementation of each HealthChoices zone and the web sites of the organizations who operate in behavioral HealthChoices.

Interviews will be scheduled at a time and location convenient to you. It is my hope that all of the interviews can be completed by the end of summer 2005 and that my data analysis and reporting are complete by the end of the calendar year. Copies of the interview questions can be sent to you prior to a scheduled meeting if you chose, in order to help prepare your responses.

As required by the university, your signed informed consent will be obtained prior to the interview process. The consent document includes information regarding security plans for the raw data, the extent of your involvement in the research, and assurances of confidentiality.

I appreciate your willingness to consider participating as I complete my doctoral studies. If you have additional questions about my research plans, I would be happy to discuss them in greater depth at your convenience. If you are willing to participate in a structured interview, I would ask that
you respond to me by DATE. I can be reached via electronic mail or telephone as noted below.

Again, thank you for your consideration. I look forward to hearing from you soon.

Best regards,

Kristina Ericson, PhD Candidate
School of Public Affairs, The Pennsylvania State University
Appendix C

Signed Informed Consent Form for Social Science Research

Title of Project: The Role of Influence in the Implementation of Public Policy: Pennsylvania HealthChoices – A Case Study

Principal Investigator: Kristina Ericson, Graduate Student
School of Public Affairs, Penn State Capital College
TELEPHONE: (505) 710-9551
EMAIL: kericson@lobo.net

Advisor: Dr. Beverly A. Cigler
School of Public Affairs, Penn State Capital College
TELEPHONE: (717) 948-6060
EMAIL: cigler@psu.edu

1. Purpose of the Study: The purpose of this research study is to explore how the influence of particular actors or groups affects the implementation of public policy, in particular the Pennsylvania Medicaid managed care behavioral health policy referred to as HealthChoices.

2. Procedures to be followed: You will be asked to provide verbal responses to a series of 25 interview questions prepared by the principal investigator that ask for your perceptions about the implementation of HealthChoices in Pennsylvania. A copy of the notes taken during the interview will be made available to you by the investigator after they have been transcribed. You will have the opportunity to make deletions or corrections to that transcription.

3. Discomforts and Risks: There is minimal risk in participating in this research. Opinions on the implementation of HealthChoices by individuals currently involved in that system could lead to embarrassment if those opinions, linked to an individual’s name, were to be released to others involved in the system. Data analysis and proposed reporting removes identifying information.
4. **Benefits:** This research is designed to add to the knowledge base that researchers and students use when studying issues of public policy, political institutions, and interest groups. As a participant involved in the public behavioral healthcare system you may benefit by having access to the final research report, which can be made available to you if requested.

5. **Duration:** It will take between one (1) and two (2) hours to complete the interview.

6. **Statement of Confidentiality:** Only the principal investigator (Kristina Ericson) and her faculty advisor (Dr. Beverly Cigler) will know your identity. The data will be stored and secured at the investigators home office in Albuquerque, NM in locked hard copy files and password protected electronic files. The Office for Research Protections and the Social Science Institutional Review Board may review records related to this project. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared.

7. **Right to Ask Questions:** You can ask questions about this research. Contact Kristina Ericson at (505) 710-9551 with questions. Questions can also be asked via electronic mail at kericson@lobo.net. If you have questions about your rights as a research participant, contact The Pennsylvania State University’s Office for Research Protections at (814) 865-1775.

8. **Compensation:** There is no compensation for participation in this research project.

9. **Voluntary Participation:** Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer.

You must be 18 years of age or older to take part in this research study. If you agree to take part in this research study and the information outlined above, please sign your name and indicate the date below.

You will be asked to sign and date two (2) copies of this consent form. Please keep a copy for your records and return the second copy to the principal investigator, Kristina Ericson.

<table>
<thead>
<tr>
<th>Participant Signature</th>
<th>Date</th>
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<tr>
<td>Person Obtaining Consent</td>
<td>Date</td>
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### Appendix D

**Interview Database Codebook**

<table>
<thead>
<tr>
<th>Question #</th>
<th>Question</th>
<th>Responses</th>
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</table>
| 1          | Describe your involvement in the Pennsylvania public behavioral health care program, HealthChoices. (zones, positions, length of time, etc.) | 1. State employee  
2. County employee  
3. MCO employee  
4. Provider/Related Interest Group employee  
5. Advocate/Consumer  
6. Southeast Zone  
7. Southwest Zone  
8. Lehigh/Capital Zone |
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<th>Question #</th>
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<th>Responses</th>
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<tr>
<td>2</td>
<td>Pennsylvania’s carve-out of behavioral health dollars from Medicaid physical health is referred to as a pivotal decision point in the development of the HealthChoices program. What opportunities did that provide?</td>
<td>1. Waylaid initial fears about managed care.</td>
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<td></td>
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<td>2. State gained early buy-in for HealthChoices from a variety of constituents.</td>
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<td></td>
<td></td>
<td>3. Enhanced the role of consumers and families in policy.</td>
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<td></td>
<td></td>
<td>4. Protection of behavioral health dollars from physical health.</td>
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<td></td>
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<td>5. Enhanced relationships among subsystems.</td>
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<td></td>
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<td>7. Preserved the current provider system.</td>
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<td></td>
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<td>8. Create a unified behavioral health system – Medicaid and state dollars in one place.</td>
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<td>9. Segregation of dollars would provide clear baseline of what was being spent on behavioral health; state could better stabilize costs.</td>
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<td></td>
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<td>10. Preserved importance of behavioral health in the insurance market.</td>
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<td>11. Enhanced role of providers because of existing relationships with counties.</td>
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<td>12. Ability to establish a single point of contact for care – no need to go through physical health plan.</td>
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| 3          | What problems or difficulties did it create? | 1. Underestimated how long it would take to operationalize; development of new state oversight structure; the enormity of starting a new system.  
2. Made the CMS waiver more complicated.  
4. Power struggles between county mental health and drug and alcohol leaders.  
5. Excessive control of treatment services by the counties.  
6. For-profit MCOs no longer able to skim profits from behavioral health.  
7. County assumption of full financial risk for the program.  
8. Counties had to develop new infrastructure to manage funds.  
9. MCOs had to learn to market to and work with county government; would have preferred to deal directly with state.  
10. State could force counties to be more efficient by having comprehensive data specific to treatment lines.  
11. Higher levels of reporting requirements for counties. |
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<th>Question #</th>
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<th>Responses</th>
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</table>
| 4         | Who do you believe were key players in the determination of carve-out and what impact did they have? | 1. Charles Curie  
2. Joan Erney  
3. Feather Houston  
4. Linda Zelch  
5. Terry Mardis  
7. Mercer Consulting  
8. Joe Rogers  
9. Mary Ellen Rehrman  
10. Governor Tom Ridge  
11. Secretary Bittenbender (Budget)  
12. Karen Snider |
| 5         | When PA first announced its move to Medicaid managed care through the HealthChoices waiver, what changes did you expect to see? | 1. Concerned would lose accountability.  
2. Greater involvement of consumers/advocates.  
3. Care to be rationed, particularly in inpatient.  
4. Rates to decrease.  
5. Move quickly to case rates.  
6. Download risk to providers.  
7. Pieces of the system to finally come together.  
8. Continued growth in BHRS and D&A services.  
9. Concern about differences among counties and inability at state to manage those differences.  
10. Development of more community support programs.  
11. Increased access to care.  
12. Alternative funding models. |
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<th>Responses</th>
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| 6          | Did those changes occur? Immediately or over time? Were those changes a result of particular individuals involved in the development of the program? | 1. Involvement of consumer/advocates increased immediately in Southeast.  
2. Growth of expenditures slowed.  
3. Personalities of key implementers make things happen.  
4. State doesn’t have much program control.  
5. Counties threaten the dollar for control of MCO and providers.  
6. Care was rationed.  
7. Continued growth in BHRS and D&A services.  
8. Savings in inpatient realized.  
9. New services not developed quickly. |
| 7          | How did you feel the Pennsylvania model compared to other state initiatives that had already been implemented? Do you feel Pennsylvania built the HealthChoices model on “lessons learned” from other states? | 1. Much learning came from Mercer Consulting.  
2. First state to implement county-based program.  
3. Better to implement regionally than entire state at once; learned from themselves rather than others  
4. Better than other states. Integrated all control in OMHSAS.  
5. Appropriately funded and actuarially sound. |
| 8          | The process of developing the regulations/policies guiding HealthChoices was lengthy. Was that a public process or limited to selected participants? Were you involved? | 1. Unsure.  
2. Implied public involved through hearings; no impact from those.  
3. Routinely involved consumers/families.  
4. DPW responsible to CMS; most planning internal. |
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| 9          | Do you believe the implementation of HealthChoices has changed over time (zone to zone)? How and why/why not? | 1. Yes  
2. No  
3. Culture of counties causes much of difference.  
4. Learned things over time – program more regulated by third round in Lehigh/Capital; standards solidified.  
5. State has matured.  
6. Counties learn from each other.  
7. More streamlined as it progresses.  
8. Learned importance of key players on board at start up in each region – state, county, and MCO levels. |
| 10         | Who were the people that had the greatest impact on the shaping of those policies and regulations? Why? | 1. Federal government, everything had to be approved by them.  
2. State.  
3. Mercer Consulting  
4. Consumers/Families; the state has had to respond to lawsuits from them.  
5. Joan Erney  
6. Charles Curie  
7. Feather Houstoun  
8. Linda Zelch  
9. Terry Mardis  
10. Jerry Koeplman |
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<th>Question #</th>
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<th>Responses</th>
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</table>
| 11         | There are differences in how HealthChoices “looks” between and within implementation zones. What do you think accounts for those differences? | 1. County-driven culture differences.  
2. Personalities/value systems of county officials.  
3. What role county officials wanted to play in the system.  
4. Involvement of advocates.  
5. How businesses operate in a county; provider capability before HealthChoices.  
6. Counties joining together to operate BH-MCO contracts.  
7. Ability to use reinvestment dollars.  
8. History of prior service system.  
9. Current financial pressures of the state as they renew contracts.  
10. Mercer Consulting very conservative and guided financial process. |
| 12         | Have there been leadership changes during HealthChoices implementation that have effected program change? Please provide examples. | 1. No.  
2. Charles Curie leaving for SAMHSA; new deputy secretary.  
3. HealthChoices not the top of anyone’s agenda now.  
4. Estelle Richman from Philadelphia to Harrisburg.  
5. Consultant layer is gone from program finally.  
6. Policy designed to survive leadership changes. |
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<th>Responses</th>
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| 13         | What influences shape the distinctions between HealthChoices programs in various counties (e.g. what services to include, practice patterns, etc.)? | 1. MCO background and experience.  
2. Making pharmacy part of physical health.  
3. Previous experience with voluntary managed care.  
4. Whoever has the most political power when implementation arrives.  
5. Whether the MCO is considered a partner or a vendor by the county.  
6. The robustness of the provider network.  
7. Service usage rates that existed prior to HealthChoices.  
8. County vision and leadership.  
9. County priorities in service development. |
| 14         | Do you think as a result of implementation across three zones that program changes have occurred at the state level? What has changed? How will that impact future implementation? | 1. No.  
2. HealthChoices is big business – resulted in new bureaus at state level.  
3. More refinement as policy progressed.  
4. State no longer interested in different and unique programs; trying to be more uniform in approach as program continues.  
5. Greater focus on children’s services. |
| 15         | Does the MCO structure (local/national, for profit/non-profit, age/experience) have any impact on the level of influence exhibited by county officials in local implementation? How and why? | 1. No.  
2. Yes, Magellan interested only in the bottom line.  
3. Home grown companies that involve county officials are more successful.  
4. Not the structure, but where risk lies.  
5. Personal relationships with MCO officials more important than the MCO structure. |
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<th>Responses</th>
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| 16 | Does the county structure (single/joinder/territory, leadership experience) have any impact on the level of influence exhibited by county officials in local implementation? How and why? | 1. No.  
2. County determines what services are included.  
3. Counties not good business managers.  
4. Commissioners and their efforts to address fiscal issues critical.  
5. Smaller counties have to band together to form critical mass. Harder than implementing on your own. More officials in relationship.  
6. Forced counties to review existing relationships.  
7. Influence comes from leaders not size. |
| 17 | What factors outside of the direct interactions among and between state officials, county officials, and MCOs has affected implementation of HealthChoices? | 1. Economy.  
2. Consultants – at state and county level.  
3. Growth in numbers of individuals eligible.  
4. State legislature – would they trust state officials or MCOs in determining model?  
5. Change in administration.  
6. Federal influence – especially CMS.  
7. Lobbyists – MCOs pouring money into campaign funds.  
8. Pharmaceutical issues from physical health programs. |
| 18 | Have any of these factors had more influence on the program than others? | 1. Economy.  
2. Growth in program eligibles. |
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<th>Responses</th>
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<tbody>
<tr>
<td>19</td>
<td>What role have advocacy organizations and other interest groups had in affecting the implementation designs of HealthChoices?</td>
<td>1. HealthChoices viewed successful nationally because of consumer/family involvement. 2. Law projects influenced after the fact through lawsuits. 3. Ray Webb well respected and had impact. 4. Every contract written to require consumer/family involvement. 5. HealthChoices would not exist without Southeast consumers.</td>
</tr>
<tr>
<td>21</td>
<td>Do those interest groups provide more impact locally or statewide?</td>
<td>1. Locally, by region.</td>
</tr>
<tr>
<td>22</td>
<td>Who has the greatest influence on the implementation model in a specific zone – the state, the county, or others?</td>
<td>1. State; that’s where the money is. 2. State; outlined parameters of program. 3. Counties; county right of first opportunity is most significant factor. 4. Advocates.</td>
</tr>
<tr>
<td>23</td>
<td>What other information do you believe is pertinent to understanding how influence affects HealthChoices implementation?</td>
<td>1. Ongoing federal changes and influence. 2. Time to complete planning and implementation. 3. Understanding impact of law projects. 4. The effect of CMS on the entire process; federal oversight changes. 5. Assuring comfort level of Pennsylvania General Assembly when recrafting policies. 6. Nothing; relationships underpin all policy development.</td>
</tr>
<tr>
<td>Question #</td>
<td>Question</td>
<td>Responses</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
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</table>
| 24        | Who else do you believe should be interviewed for this research (share current list)? | 1. Kathy Wells, former president of PMHCA.  
2. Terry Mardis, OMHSAS.  
3. Joe Rogers, Mental Health Association of Southeast PA  
4. Representative Denny O’Brien  
5. Pat Valentine, Allegheny County  
6. Denise Macerelli, Western Psychiatric Institute & Clinic |
### Appendix E

**Record Review Template**

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<tr>
<th>Document Type</th>
<th>1. Southeast start date.</th>
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<td>2. Southwest start date.</td>
</tr>
<tr>
<td></td>
<td>3. Lehigh/Capitol start date.</td>
</tr>
<tr>
<td></td>
<td>4. OMHSAS Readiness Review Team Leader</td>
</tr>
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<td></td>
<td>5. Carve out background.</td>
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<td>2. Shared risk with MCO.</td>
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<tr>
<td></td>
<td>3. Risk downloaded to MCO.</td>
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<tr>
<td></td>
<td>4. Direct contract state/MCO.</td>
</tr>
<tr>
<td></td>
<td>5. New standards added.</td>
</tr>
<tr>
<td></td>
<td>6. Adjustment to implementation start dates.</td>
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</table>

<table>
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<th>Document Type</th>
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</tr>
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<tbody>
<tr>
<td></td>
<td>2. Changes from original 1996 RFP.</td>
</tr>
<tr>
<td></td>
<td>3. Readiness Review process design.</td>
</tr>
</tbody>
</table>
Region Addressed

- Southeast
- Southwest
- Lehigh/Capitol

Addresses  No Information
Proposition #1: Patterns of influence that affect the implementation of behavioral health in Pennsylvania are consistent across regions that have implemented the Medicaid managed care program, HealthChoices.

Addresses  No Information
Proposition #2: The impact of influence at the county (local) government level is greater than the impact of state bureaucracy in program implementation, creating differences in the HealthChoices program across regions.

Addresses  No Information
Proposition #3: A collaborative relationship between county government and the contracted managed care organization increases variance in implementation from the HealthChoices program as defined by the state.
Appendix F

Documents Reviewed – Influence in HealthChoices


VITA

Kristina L. Ericson

Ms. Ericson holds a Bachelor of Arts in psychology from Bethany College, Lindsborg, KS, and the Master of Psychosocial Science in community psychology from The Pennsylvania State University – Capital College, Harrisburg, PA. With an extensive background in public behavioral health treatment and service delivery systems, she is the sole proprietor of Ericson Consulting and provides system training, program and policy development, strategic planning, and regulatory guidance to a variety of clients. Ms. Ericson is also executive director of The American College of Mental Health Administration (ACMHA), an independent professional membership organization of mental health administrators from a broad variety of disciplines.

Her areas of interest and research include Medicaid, public policy, state government, leadership, and public management. She is a member of the American Society for Public Administration and The American Political Science Association.