CENTER for STUDYING HEALTH SYSTEM CHANGE

Issue Brief

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Public Health Departments Adapt to Medicaid Managed Care

By Rose Marie Martinez and Elizabeth Closter, Mathematica Policy Research, Inc.

Millions of Medicaid beneficiaries have recently moved into private managed care plans across the country. Public health departments—which have acted as providers of primary care and other services for some Medicaid patients—are often not explicitly included in contracts between these designated Medicaid plans and the states. As a result, many of the 3,000 city and county public health agencies nationwide have lost both patients and significant revenue to plans. This Issue Brief describes how public health departments are adapting to this shift in state policy. According to our research conducted in 1997, many are de-emphasizing the delivery of direct health care services in favor of core public health functions, such as investigating community health problems and health promotion. Some are initiating new partnerships with Medicaid managed care plans.

MEDICAID MANAGED CARE

Public health departments have long been a significant component of the nation's health care safety net. Along with hospitals, community health centers and federally qualified health centers, public health departments comprise a loose infrastructure of providers that care for people, regardless of their ability to pay. Medicaid recipients have been an important customer base for public health departments, because Medicaid has traditionally reimbursed the departments on a fee-for-service basis for primary care and other services delivered to its beneficiaries.

In recent years, however, nearly every state has moved or plans to move its Medicaid population into managed care. As a result, Medicaid recipients are more likely to obtain primary care services from private providers in their managed care network than from public health departments. As Medicaid beneficiaries have more choices of where to obtain care, health departments risk losing—or, at best, sharing—a substantial number of Medicaid clients and the revenue that comes with them.

The impact of this policy shift has varied in type and intensity around the country, for example:

- In the past, the Ingham County Health Department (ICHD) of Lansing, Mich., had the lead role in providing and ensuring the quality of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) services to both Medicaid and uninsured clients. Now, the program has been divided in two—one serving the Medicaid population through HMOs, and the other serving the uninsured at local health departments. This division is compromising ICHD's ability to conduct the population-based activities of tracking the delivery and quality of care across the whole low-income population.
- In Little Rock, Ark., loss of EPSDT activities to state-contracted health plans has resulted in a 30 percent drop in the local health department's Medicaid revenue. The Department of Health spends about 70 percent of its budget on direct clinical services, so as a result Arkansas's 1994 Medicaid waiver is forcing a comprehensive reappraisal of the health department's mission and role.

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Study Methodology

This Issue Brief is based on a 1997 study of 12 public health departments, which was conducted by Rose Marie Martinez and Elizabeth Closter of Mathematica Policy Research, Inc. It was initiated and funded by the Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion. The report's conclusions reflect initial market assessments in a two-year study that tracks a sampling of health departments over time. A follow-up study will be conducted during 1998 and 1999.

The survey is an adjunct to HSC's Community Tracking Study, a longitudinal study that focuses on changes in the health system in 60 sites that are representative of the nation. Site visits and more in-depth surveys are conducted in the same 12 communities covered in this Issue Brief.

Mathematica gathered data through on-site interviews and from surveys by the National Association of County and City Health Officials and the National Association of Local Boards of Health. Mathematica also drew from a report by the George Washington University Center for Health Policy that details Medicaid managed care contracts in 36 states plus the District of Columbia, including nine of the 12 study sites.

- In Cleveland, the Cuyahoga County Board of Health is typical of health departments that have not provided personal health services to Medicaid beneficiaries for some time. Cleveland's Board of Health is experiencing fewer changes as a result of Medicaid reform.

As these examples illustrate, states have pursued different approaches with respect to integrating health departments into the provision of services for Medicaid beneficiaries.

STATE CONTRACTS LACK CLARITY

As states develop contractual relationships with Medicaid managed care plans, a number of health departments have been given an explicit, albeit limited, role in this new environment. Most contracts, however, lack clarity about the role of the health department. Where there is this level of clarity, two models are emerging: reimbursing local health departments for Medicaid services, even though the departments are not part of the formal managed care networks; and requiring Medicaid managed care plans to collaborate with local public health departments on specific services such as infectious disease control.

State Medicaid contracts generally encourage health plans to form relationships with a wide variety of public health agencies, including school health clinics, homeless health providers and state senior services. But rarely do the states set specific requirements for comprehensive involvement of the public health departments. For example, in several states, Medicaid contracts allow referrals to "any qualified family planning provider," but do not specifically name public health departments. Some state contracts are more likely to spell out a role for local health departments on a service-by-service basis, particularly infectious diseases. In California, for example, the state contract specifies that tuberculosis patients requiring directly observed therapy be referred to the local health department.

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But in general, with respect to both care for and control of communicable diseases, contracts between plans and the states reflect a clear shifting of the responsibility and the revenue stream from health departments to health plans. Contracts generally specify that prevention and treatment be included in the Medicaid managed care benefit package, but again, the role of local health departments is not clearly spelled out. Primarily, plans are required to report instances of diseases back to the local health department.

EPSDT services have proven to be an especially tricky component of the state/health department/health plan relationship. These include a wide range of screening services aimed at marking critical stages of childhood development, including immunization, vision and hearing exams, mental health screening and lead poisoning screening. Historically central to the health department mission in most places, EPSDT services have been largely shifted to health plans under Medicaid managed care. Coordination between health plans and local health departments in the delivery of some EPSDT services is important because health plans do not always have the systems necessary for meeting all EPSDT requirements, such as those associated with responding to positive lead poisoning screens.

Many contracts are similarly vague with respect to how health departments might get paid for services rendered for which primary responsibility has shifted to managed care providers. Where payment is specified, health departments often must receive prior authorization from the plan before services are administered.

It is not surprising that states have not thought about specific roles for health departments as Medicaid managed care has become more the norm. Even under fee-for-service, states have not done particularly well at coordinating care between different entities and different types of providers. Now, some states are concerned about having different delivery systems for the same clients. Moreover, other

states have not generally thought of public health services as a part of the traditional package of health care services that need to be purchased, and some states do not believe that health departments should be involved in the delivery of any kind of direct clinical services.

THREE PARTNERSHIPS CLOSE UP

Some local health departments have taken aggressive steps to respond to Medicaid managed care through formal relationships with their state programs. Health departments in three study sites, Dade County Health Department in Miami, Fla., Onondaga County Health Department in Syracuse, N.Y., and Orange County Health Department in California, have crafted partnerships through memorandums of agreement (MOAs) that allow the state, health plans and health departments to clearly address how certain concerns and issues will be handled in this new environment. These include:

- coordinating patient services and information between health departments and Medicaid managed care plans;
- integrating traditional public health functions, such as health promotion and disease prevention, into managed care plans; and
- establishing a formal system of reimbursement for health departments that provide services that are part of a managed care plan's benefit package.

Dade County, Miami. An MOA between the state, Miami's Dade County Health Department (DCHD) and 10 participating health maintenance organizations (HMOs) emphasizes the responsibilities of each partner, a reimbursement system for services provided by the DCHD and the means of exchanging information between the HMOs and the health department. DCHD remains responsible for promoting the public's health, controlling and eradicating preventable diseases and providing primary health care for special populations. The HMOs are specified as subcontractors to the Florida State Agency for Health Care Administration (which administers the Medicaid program).

The HMOs pay the DCHD for immunization services, family planning services and related medications and diagnostic and treatment services for communicable diseases, including STDs. These services may be given without prior authorization. HMOs are also required to help eligible beneficiaries make contact with the DCHD for services they need. For example, plans must refer all eligible women to DCHD for Healthy Start pre- and postnatal screening.

Provisions governing the exchange of information between plans and the county health department involve a tremendous amount of detail. Among other requirements, the DCHD must try to notify the HMO before providing care for its members (for administrative purposes such as quality reporting, not for prior authorization), and it agrees to quickly provide the HMO with immunization records for plan members. Meanwhile, the HMO must provide the health department with any records that will assist in the latter's effort to track and prevent communicable diseases.

Onondaga County, Syracuse. In Syracuse, N.Y., where 50 percent of Medicaid beneficiaries are in managed care and where there is a declining public health department role in clinical service delivery, MOAs were executed with four health plans. The goal, according to the Onondaga County Health Department (OCHD), is to provide an integrated system of high-quality, cost-effective public health and managed care services. Under the agreement, OCHD has three basic functions:

- monitoring preventive services and identifying related problems among managed care recipients as well as the general population;
- linking the clinical activities of the OCHD and the plans vis-à-vis population-based efforts to control STDs, tuberculosis, HIV and some child health problems; and

Some health departments are developing formal and informal relationships with Medicaid managed care plans.

Health Departments Participating in the Study

Phoenix, Ariz., Maricopa County Department of Public Health

Little Rock, Ark., Pulaski Central Health Unit

Orange County, Calif., Health Care Agency of Orange County

Miami, Fla., Dade County Health Department

Indianapolis, Ind., Marion County Health Department

Boston, Mass., Boston Public Health Commission

Lansing, Mich., Ingham County Health Department

Newark, N.J., Newark Department of Health and Human Services

Syracuse, N.Y., Onondaga County Health Department

Cleveland, Ohio, Cuyahoga County Board of Health

Greenville, S.C., Appalachia II Public Health District

Seattle, Wash., Seattle-King County Health Department

- "facilitating" disease surveillance and environmental health.

Tuberculosis control is a key part of the joint agreement that relates to communicable diseases. Participating Syracuse health plans are required to refer all active and suspected TB cases to the health department. From that point, care of TB cases becomes a collaborative effort, with the OCHD carefully monitoring the health plan's treatment and even developing schedules for medication and home visits. The protocol for care does not depart from established health department procedures, but the innovative aspect of the MOA is that the OCHD is reimbursed by the plan for providing population-based services and surveillance as well as disease control.

Some aspects of the MOA go beyond the public health programs provided by OCHD. Participating Syracuse health plans, for example, are required to refer children who are not gaining weight and developing properly to the New York State Department of Health's Infants-Child Health Assessment Program. To meet the requirements of this program, these health plans engage the services of public health nurses, who conduct home visits and administer a range of clinical and educational services to the children who fall into high-risk groups.

Orange County. CalOPTIMA, a public agency, contracts with providers and health plans in Orange County for California's Medicaid program, called Medi-Cal. The Orange County Health Care Agency (HCA), facing losses in patient visits and revenue to Medi-Cal managed care plans, developed a series of MOAs with CalOPTIMA to delineate the responsibilities of each organization in coordinating care for the Medi-Cal population. Twelve specific areas of service are covered in these MOAs, including HIV programs, pulmonary diseases, children's health and disability prevention, lead poisoning control and epidemiology.

The MOA governing HIV control is particularly detailed and explicit. It describes the responsibilities of HCA and CalOPTIMA as they affect the testing, detection, reporting, care, education and prevention of HIV. CalOPTIMA is responsible for ensuring that its HIV-infected clients receive appropriate care. HCA, meanwhile, is responsible for public education and tracking down partners of infected individuals to notify them that they should be tested for HIV, and for providing HIV ambulatory care services for non-Medicaid clients.

FINDING THEIR OWN WAY

Medicaid managed care simultaneously poses both threats and opportunities for public health departments. In particular, those that have been heavily oriented toward delivery of clinical services are having to reassess their structure and mission as plans become responsible for many of the services that health departments had historically delivered. States have not been as active as they could have been in clarifying a role for health departments in a privatized Medicaid system, but some health departments are finding their own way by developing formal and informal relationships with Medicaid managed care plans. Absent the states specifying such roles, health departments that are more aggressive about partnering with managed care plans can better ensure their place in, and contribution to, the evolving and varied health systems that exist across the country at the local level.

Researchers are now going back into the field to better understand a number of issues, including:

- What are the implications for the population at large of dividing up functions that had previously been integrated: surveillance of infectious diseases and delivery of related care and services for infectious diseases?
- Could health plan mergers or withdrawal from Medicaid managed care have a negative impact on public health departments and the patients they have traditionally served?
- Could health departments' shifts to accommodate Medicaid managed care make it harder for them to serve the non-Medicaid population for whose care they have historically not been reimbursed?

Careful scrutiny of the successes and challenges posed by these emerging partnerships should prove valuable to local public health departments that are only now formulating a new posture for the changing health care environment, as well as to their plan partners and to policy makers at the state and federal levels. ■

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