A Study of Collaboration Between Medicaid Managed Care Organizations and Local Departments of Health in New York State

A Report Prepared for the New York State Department of Health, Office of Managed Care

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PREFACE

The number of New Yorkers enrolled in managed care, including individuals covered by Medicaid, has increased significantly over the past decade. As managed care plans have assumed greater responsibility for an array of clinical and preventive services, it has become more important for managed care organizations (MCOs) and local departments of health (LDHs) to clarify and coordinate their roles in the provision of those services. There is a growing consensus on the need for cooperation between managed care organizations and local departments of health. Additionally, these developments pose new opportunities and challenges to public health departments as they fulfill their core public health functions.

To better understand the relationships and responsibilities of MCOs and LDHs, particularly around preventive and public health services, and to develop recommendations to improve the delivery of the shared services, the New York State Department of Health (SDOH), Office of Managed Care contracted with the Center for Health Workforce Studies at the School of Public Health, University at Albany, SUNY.

Key Center staff on this study were: Steven Schreiber; Jean Moore; Shritapa Mohapatra; Leandra Payne and Edward Salsberg. The study could not have been conducted without the cooperation and insights of the survey respondents and the interview participants. The Center also acknowledges the assistance of staff in the SDOH who provided invaluable guidance to the study, including: Barbara Frankel, Foster Gesten, MD, and Christine DiCaprio in the Office of

Managed Care; and Sylvia Pirani in the Center for Community Health. The Center also acknowledges the contribution of the project workgroup to this study. The workgroup listed in Appendix A, provided very valuable advice and guidance in the development of the mail survey instruments, the selection of the counties and staff for the in-depth interviews, and the interpretation of the study results.

The views expressed in this report are those of the Center for Health Workforce Studies and do not necessarily reflect the positions of the University at Albany, the School of Public Health, or the New York State Department of Health.

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EXECUTIVE SUMMARY

Background

New York State requires managed care organizations (MCOs) with Medicaid Managed Care contracts to enter into agreements with local departments of health (LDHs). The state has also developed guidelines for these agreements. To learn more about these agreements, the New York State Department of Health (SDOH) convened a workgroup consisting of representatives of LDHs in counties that had begun the process of negotiating agreements. The workgroup acknowledged the value of dialogue between the MCOs and the LDHs and raised numerous concerns about the need to clarify roles, address financing issues for LDH services, and identify data for monitoring and quality assurance purposes.

In light of the above developments, SDOH sought to obtain more complete information on the nature of the collaborative agreements developed to date, the factors that promote or impede collaboration, and the changes in programs or procedures at the state and local levels that could improve the collaborative process. In 2000, the SDOH contracted with the Center for Health Workforce Studies at the State University of New York (SUNY) at Albany, School of Public Health to study these issues. The goals of the study were to describe the collaborative arrangements developed, assess perceived strengths and

weaknesses of the various approaches, identify factors involved in successful collaboration, and provide policy and program recommendations to improve collaboration between the MCOs, LDHs, and Local Departments of Social Services (LDSSs).

A project advisory group, consisting of representatives from LDHs, MCOs, LDSSs, and SDOH, provided guidance on the design of the study. The study design had three main components:

1. A review of the literature on LDHs/MCOs collaboration;
2. A mail survey.
3. In-depth, in-person interviews with the LDHs and their associated MCOs and LDSSs in seven (7) counties: Albany, Chautauqua, Erie, Monroe, New York City (for the purposes of this study, New York City is described as a single county), Onondaga, and Westchester.

Results

Mail Survey

The mail survey, conducted between June and September of 2001, was sent to 83 people representing the twenty-seven (27) LDHs, their associated MCOs and LDSSs that had collaborative agreements in place. The study included questions on the type of collaborative agreement, the impact on the service delivery system, the administrative arrangements to support the LDH/MCO collaboration, the types of and effectiveness of the collaboration, an assessment of factors that promote or impede collaboration and ways to enhance collaboration. The survey also asked the respondents to describe what measures the SDOH could undertake to foster collaboration. Several of the themes covered in the open-ended responses were used to formulate the questions for the in-depth interviews. The survey generated 67 responses with an overall

response rate of 81%. The LDHs, the LDSSs, and at least one MCO responded from counties accounting for 85% of the Medicaid managed care population.

Interviews

Twenty-three interviews were conducted in late 2001. The goal of the interviews was to obtain a more in depth understanding of the principal areas covered in the mail survey: 1) the activities through which collaboration between LDHs and MCOs takes place; 2) the factors that provide or impede collaboration; and 3) suggestions to the SDOH on ways it might promote LDH MCO collaboration.

Summary of Findings (Mail Survey and Interviews)

1. **A system of written agreements appears to provide a framework for interaction between MCOs, LDHs, and LDSSs.**
   With the exception of two counties, all counties surveyed had formal written Medicaid managed care public health agreements. The Memorandum of Agreement was the most frequently reported (52%) form of agreement between the LDH and the MCO. In twenty-eight percent of the surveyed counties, the agreement was an appendix to the Medicaid managed care contract. The majority of the LDHs, MCOs, and LDSSs reported activity related to the public health agreements. The majority of the LDH and MCO respondents reported designating liaisons to work with other agencies, attending one or more public health managed care related meeting(s) in the last 12 months and having written internal policies/staff training for at least one area critical to LDH/MCO relationships (e.g., communicable disease or patient referrals). The majority of the LDSSs reported arranging meetings, assisting in identifying problems, and providing technical assistance.

2. **The LDHs and MCOs reported working together on specific public health issues**. Seventy-seven percent of MCOs reported participating in LDH sponsored community education/outreach activities and forty-one percent of MCOs reported participating in community health assessments. Seventy-seven percent of the MCOs

reported working with LDHs to improve their plan's performance on public health measures. The MCOs identified immunization rates as the most common plan performance area for LDH/MCO collaboration. Although the percentage rates are lower, LDHs also reported MCO participation in education/outreach activities (forty-four percent), community health assessment activities (twenty percent), and working with MCOs on plan performance (forty eight percent).

3. **There appear to be several examples of successful collaborations.**
   In the written survey, all but one of the MCOs reported a good or excellent relationship with at least one LDH and fifty-nine percent of the LDHs reported a good or excellent relationship with at least one MCO. The interviews identified encouraging examples of increasing alignments of LDH/MCO interests. Several counties reported collaboration on high-risk pregnancies. One county had a diabetes coalition that involved MCOs, SDOH, the LDH, the Academy of Family Practice and the American Diabetes Association.

   Respondents identified several factors that led to successful collaborations**.** LDSS, LDH and MCO respondents found that interpersonal relationships and attitude affected the outcomes. Respondents identified leadership, staff who understood public health and managed care, participatory management style, flexibility, and willingness to listen as important to successful collaboration. In particular, respondents identified the support and leadership of the LDSS as important.

   Counties that had formal existing structures for collaboration in other areas seemed to have an advantage. In several counties, the three agencies already had regular meetings. Some interview participants indicated that facilitated enrollment in Child Health Plus and Family Health Plus led to increased LDH/MCO communication. There were multi-county coalitions that MCO respondents with contracts in several counties identified as effective. Study respondents also indicated that positive outcomes from one collaborative effort promoted future efforts. Finally, a few

respondents commented that the need to respond to bio-terrorism might promote greater need to coordinate LDH and MCO activities.

4. **Both MCOs and LDHs identified problems and areas requiring improvement.** While the majority of LDHs, MCOs and LDSSs reported successful examples of collaboration, there were LDHs and MCOs without liaisons, regular meetings, internal policies, and staff training or collaborative public health activities. Many of the respondents focused on problems of communicating patient financial and clinical information between LDHs and MCOs. MCOs reported problems with timely LDH claims and clinical information. LDHs identified referral procedures and reimbursement for tuberculosis and immunizations as problematic. In the written survey, only thirty-six percent of the LDHs reported having the necessary infrastructure to communicate financial or clinical information to MCOs.

   Some MCOs reported concerns about unrealistic expectations of an MCO's ability to address public health problems that may require the coordinated efforts of a number of players. In particular, MCOs mentioned communicable disease reporting as an area where changing provider reporting behavior would require more than just MCO action.

   The respondents identified a variety of factors that impeded the collaboration process. All three types of respondents provided examples where negative attitudes and poor understanding of public health or managed care delivery systems and issues produced poor cooperation between the programs and negative results. Although there were examples of LDHs and MCOs working towards a common goal, some LDHs and MCOs mentioned the difference between public health and managed care goals/missions as problematic. According to some respondents, the county's experience with managed care may also affect MCO/LDH collaboration. MCO interview respondents stated that collaboration was less well developed in counties that had only recently begun to serve Medicaid enrollees. Role confusion was also identified as a factor. Respondents mentioned the potential conflict of interest that

exists when an LDH assumes the role of both a monitor of MCOs and a provider of services and concerns about LDH willingness to relinquish the direct provision of health care services to the MCOs. MCOs with multi-county contracts created challenges for the collaboration process. MCOs found the different LDHs' policies administratively difficult and LDHs found working with corporate offices outside of the county problematic. Another factor that could impede LDH/MCO collaboration was when the LDSS did not consistently serve as an advocate for the enrollee with both the LDH and the MCO.

All three types of respondents identified larger system issues that limited their ability to assure community access to quality health and public health services. Not directly related to the managed care public health agreement process, these issues included the complex array of publicly funded health programs, limited resources, and changes in health coverage for managed care members. Some LDHs claimed that the turnover of Medicaid patients enrolled in a plan created a major disincentive for the plan to provide preventive services and made local coordination of services difficult.

5. **Both MCO and LDH respondents reported using data provided by the SDOH in the collaboration process.**
   Not surprisingly, the MCOs were more active users of the two managed care related reports: Quality Assurance Reporting Requirements (QARR) and Medicaid Encounter Data Systems (MEDS) and LDHs were more active users of New York State Public Health data. Both LDH and MCO respondents were interested in better ways to share clinical and public health data. In particular, both asked for county level data instead of plan level data that covers more than one county.

6. **While not required by SDOH as part of the public health agreements, a significant number of LDHs have agreements with MCOs to provide health care services.**
   Fifty-five percent of LDHs reported contracts with MCOs in the service areas of home health, family planning, prenatal care, domestic violence, etc. Prenatal care

was the most common contracted service with eighteen LDHs reporting MCO contracts for LDH provision of prenatal care. Consistent with a national trend observed since the late 1990s, LDHs in NYS are transitioning their direct delivery services to other providers and refocusing resources on more population-based services.[1] Fifty-six percent of the LDHs reported reducing their delivery of health care services such as well child clinics. Seventeen percent of the LDHs reported providing new enabling services, such as outreach worker assistance in Child Health Plus and Medicaid enrollment. One LDH reported increasing responsibility in coordinating services for Medicaid managed care enrollees.

Recommendations

Based on the findings of this study, the following are recommended actions that SDOH could take to improve collaboration between the MCOs, LDHs and LDSSs:

1. **SDOH should continue to require that Medicaid and Family Health Plus MCOs have agreements with LDHs.**
   While the existing written agreements do not necessarily guarantee collaboration**,** the agreements have created an opportunity and a format for collaborative activities. SDOH should provide technical assistance and training where appropriate to ensure that all parties have an understanding of the purpose and intent of the agreements. In particular, SDOH should provide training and technical assistance to counties where significant Medicaid managed care enrollment is relatively new.

2. **SDOH should create a forum for sharing best practices.**
   The array of collaboration activities undertaken by LDHs, MCOs and LDSSs is impressive and reflects a wide range of local conditions and diversity of organizational arrangements. All but one of the MCOs reported a good or excellent relationship with at least one LDH and 59 percent of the LDHs reported a good or

[1] National Association of County and City Health Officials, *Local Public Health Agency Infrastructure, A Chartbook,* October, 2001. P.18.

excellent relationship with one MCO. There should be a structured way to share information about the various arrangements among all the participants. This might include an annual conference, written descriptions of effective collaborations and annual recognition awards.

3. **As a source of current health and public health information, the SDOH should provide technical assistance to MCOs and LDHs in data acquisition, analysis, reporting and use.**

   SDOH should build on existing approaches to expanding access to data for both quality assurance and community health planning purposes[2]. SDOH should continue to explore the capabilities of generating data in different formats that meet local needs (e.g., producing data by county and providing public health related data such as immunizations, lead screening, etc.). Either as part of existing SDOH workgroups or as a separate workgroup, SDOH should provide a forum for MCO, LDH and LDSS representatives to review existing data sources (Quality Assurance Review Reports, consumer surveys, special studies, public health reports/data) and identify access, training and new data needs.

[2] Since 1998, the SDOH has used grants from the CDC (Assessment Initiative) and the Robert Wood Johnson Foundation (Turning Point Initiative) to strengthen community health assessment capacity and practice. An outgrowth of the Assessment Initiative is the Community Health Clearinghouse: a user-friendly tool to provide community health practitioners with access to local, state and national public health data sets, resources and tools to assist the practitioners conduct effective community health assessment processes. Work has begun to identify QARR indicators that are useful for public health planning, surveillance and assessment purposes, and can be placed on the Community Health Clearinghouse.

BACKGROUND

There is a growing consensus on the need for cooperation between managed care organizations (MCOs) and local departments of health (LDHs). As MCOs have assumed greater responsibility for an array of clinical and preventive services, it has become more important for MCOs and LDHs to clarify and coordinate their roles in the provision of those services. Additionally, these developments pose new challenges and opportunities to public health departments in the fulfillment of their core public health functions of assurance, assessment and policy development.

The 1999 New York State Medicaid Managed Care contract (Section 10.18) required the development of public health agreements between MCOs and LDHs. The state has developed guidelines for local departments of social services (LDSSs) to use in designing the agreements. A survey conducted in 1999 by the New York State Department of Health (SDOH) found that of the 44 counties enrolling recipients in Medicaid managed care, 27 counties including New York City had completed negotiations for the agreements. Sixteen had no agreements. (There was one non-respondent). These agreements were found to vary widely in their degree of formality and scope of services.

In 1999, the SDOH convened a workgroup consisting of representatives of LDHs in counties that had begun the process of negotiating agreements. The workgroup acknowledged the value of dialogue between the MCOs and the LDHs, and also raised numerous concerns about the need to clarify roles, address financing issues for LDH services, and identify data for monitoring and quality assurance purposes.

In light of the above developments, the SDOH, in 2000, sought to obtain more complete information on the nature of the collaborative agreements that have been developed to date, the factors that promote or impede collaboration, and the changes in programs or procedures at the state and local levels that could improve the collaborative process. To this end, the SDOH contracted with the Center for Health Workforce Studies in the School of Public Health at the University at Albany SUNY to study these issues.

Goals of the Study

The goals of the study were to:

- Describe the collaborative arrangements that have been developed between MCOs and LDHs.
- Assess the perceived strengths and weaknesses of various approaches to structuring the collaboration between MCOs and LDHs, based on results to date.
- Identify the factors involved in establishing successful collaborations.
- Provide policy and program recommendations to improve the process for developing collaborations between the MCOs, LDHs, and LDSSs.

Methods

1. **Establishment of a Project Advisory Group**

   A project advisory group was established, consisting of representatives from LDHs, MCOs, LDSSs, and the SDOH. On March 30, 2001, the Project Advisory Group met to review the initial design of the study. Drafts of survey instruments were

subsequently sent to the advisory group for comment. On August 1, 2001 a conference call was held with the advisory group to review the initial findings of the mail survey and to discuss the next steps for the in-depth interviews.

2. Study Design

The study design had three main components.

1. A review of the literature on LDH/MCO collaboration was completed. To develop a conceptual framework for the study, a search of the literature on LDH/MCO collaboration was conducted, using the database of the National Library of Medicine accessed through its "Pub Med" search engine. While there were numerous articles examining the impact of managed care on public health, there were only about a dozen that specifically examined models of collaboration between LDHs and MCOs. The literature review was most useful with respect to providing insight into the types of collaborative models. The literature review suggested that the collaboration process is effected by the health care market structures, the characteristics of the participating managed care organizations/public health agencies, the participants' level of experience with the managed care / public health collaboration process, MCO/ public health agencies' organizational goals, and MCO / public health agencies' roles and responsibilities. The review identified problem areas that would limit collaboration process: 1) divergent roles and responsibilities with public health agencies responsible for the entire communities and MCOs for their enrolled populations; and 2) the impact of managed care on public health agencies' revenues and roles as direct service providers. The review also suggested areas for collaboration: health planning and development, outreach and education, data collection, community health assessment, provision of enabling services, provision of clinical services, and case management. The review included reasons for collaboration: the "need to learn from each other" and the promotion of prevention-oriented social and economic policies (e.g., tobacco control). The literature review and a list of the articles reviewed appear in Appendix B.

2. A mail survey (both regular mail and an e-mail option) was conducted of the 27 LDHs and their associated MCOs, and LDSSs that have collaborative agreements in place. Each of the three groups received its own survey, although there were several questions common to all of the survey instruments. Copies of the survey cover letter and instruments appear in Appendix C. Non-respondents received a follow up request and survey, which was sent a second time, if necessary. Survey data were collected from June 2001 to September 2001. The organizations that completed the mail survey are listed in Appendix D.

3. In-depth, in-person interviews were conducted with the LDHs and their associated MCOs and LDSSs in seven counties: Erie, Monroe, Onondaga, Westchester, New York City (for the purposes of this study, New York City is described as a single county), Albany and Chautauqua. Interviews were conducted with the LDHs, LDSSs, and MCOs that responded to the mail survey. A list of the respondents and their organizations is included as Appendix E. The first five counties listed in this section comprise 80% of the total number of Medicaid enrollees in managed care in New York State. In the case of New York City, the presence of a large number of MCOs precluded interviewing all the MCOs that serve Medicaid populations. We selected for interview those plans that responded to the mail survey and had the larger number of Medicaid enrollees. The seventh county, Chautauqua, was selected to provide a more rural perspective on LDH/MCO collaboration issues.

Quantitative survey responses were coded and entered into SPSS 9.0 (Statistical Package for the Social Sciences, version 9.0) for processing. Results were then presented in charts using MS Excel. Open-ended responses were transcribed and grouped by question and respondent type (LDH, MCO, LDSS) and summarized into general categories.

Findings

Mail Survey Results

1. Response Rate

There were 67 responses of a possible total of 83 for an overall response rate of 81%. The breakdown of the response rate was as follows:

- LDH, 25 responded out of a possible 27 (93%)
- MCO, 17 responded out of a possible 29 (59%)
- LDSS, 25 responded out of a possible 27 (93%)

Three MCOs and one LDH submitted responses after the final extension deadline and were not included in the survey results.

The LDHs, LDSSs, and at least one MCO responded for the following counties, which comprise 85% of the Medicaid population enrolled in managed care.

- Albany
- Chautauqua
- Erie
- Monroe

- New York City
- Onondaga
- Westchester

2. Responses

The survey responses are presented in the following categories:

- Types of collaborative agreements
- Service delivery impact of managed care
- Administrative arrangements in support of LDH/MCO collaboration
- LDH/MCO collaboration in public health activities
- Assessment of effectiveness of the collaborative process
- Assessment of factors that promote or impede collaboration

Types of Collaborative Agreements

Figure 1
Number of LDHs Reporting Agreements with MCOs
by Type of Agreement

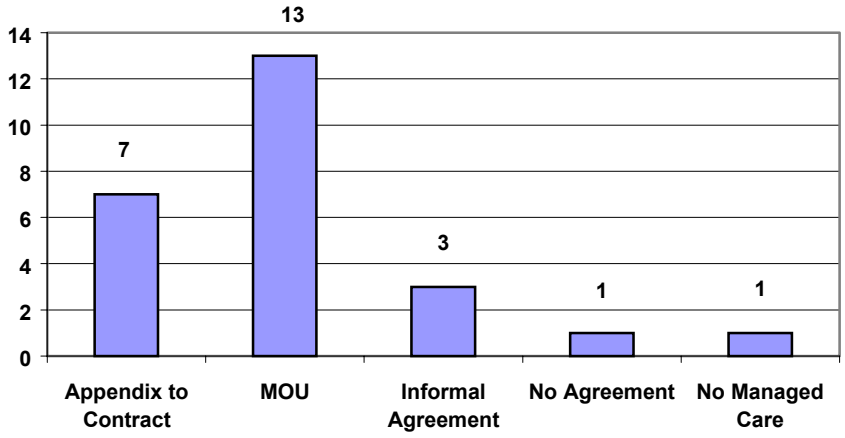


Figure #1 shows that the main form of agreement between the LDH and the MCO as reported by the LDH was the Memorandum of Understanding (MOU) (13), followed by the appendix to the contract (7), and the informal agreement (3), one LDH reported no agreement and one reported no managed care.

Service Delivery Impact of Managed Care

Figure 2
Percent of LDHs Reporting Changes in Health Services as a Result of Managed Care

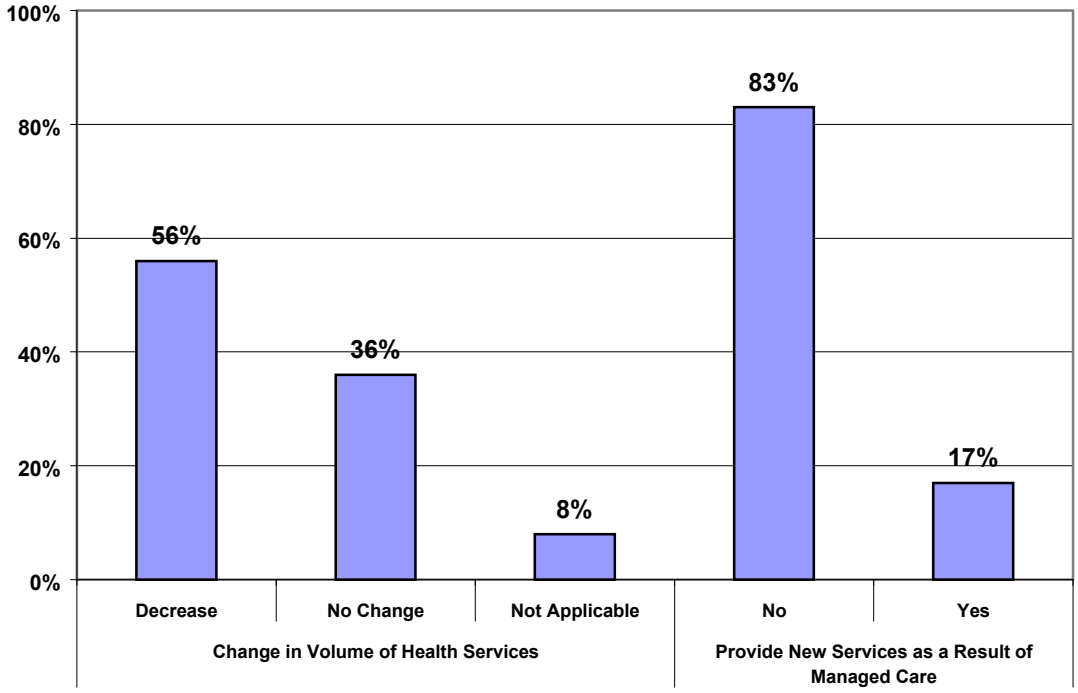


Figure #2 shows that most LDHs (56%) reported a decrease in their delivery of health care services, such as well child clinics. Thirty-six percent reported no change and 8% gave a "not applicable" response, presumably because their departments were not involved in the direct delivery of health care.

Seventeen percent of the LDHs reported they were providing new services as a result of Medicaid managed care. An example of a new service reported is outreach worker assistance in Child Health Plus and Medicaid enrollment.

Administrative Arrangements in Support of LDH/MCO Collaboration

Figure 3
Percent Reporting Liaisons or Meetings with LDHs or MCOs

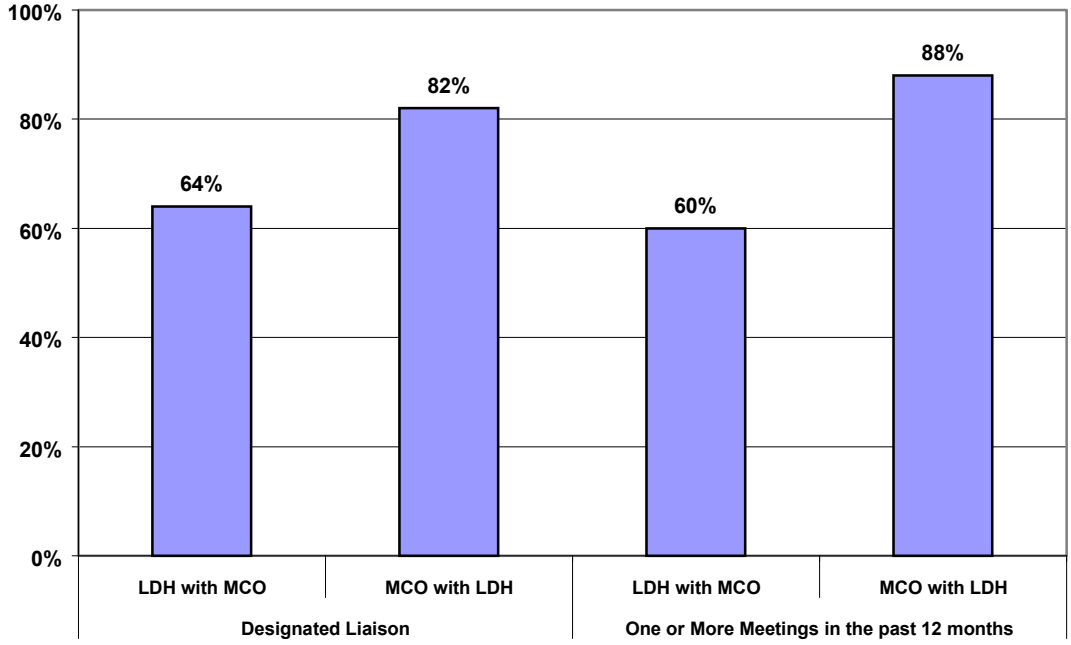


Figure #3 shows 64% of the LDHs and 82% of the MCOs stated that they had appointed liaisons with respect to the implementation of the collaborative agreements. Twenty-three out of 25 counties gave detailed information (not shown) on the level of person(s) assigned as liaisons. Most of the LDH-designated liaisons were Commissioners, Deputy Commissioners, Assistant Commissioners, Directors of Public Health, or Directors of Patient Services. A similar picture prevailed with the LDSS respondents. For the MCOs, the typically designated liaisons were Medical Directors, Chief Medical Officers or Managers of Government Relations.

Sixty percent of the LDHs and 88% of the MCOs reported one or more meetings with the MCO (or LDH) in the past 12 months. The LDHs reported an annual number of meetings ranging from 1-30 with a median of 4. The MCOs reported an annual number of meetings ranging from 1-30 with a median of 8. NOTE: Differences in the percentage of

affirmative answers to a question by the LDH and the MCO regarding an event in common do not necessarily mean that the two groups have different views of that event. These differences can result from the fact that the number of MCOs that serve the Medicaid population varies widely by county. For example, the New York City Health Department (one of 25 LDHs participating in the study, or 4% of the total number of LDHs), deals with 18 MCOs (18 of 29 total MCOs or 62% of the total number of MCOs). Since multiple MCOs deal with New York City's LDH, their experiences with that one LDH can consequently skew survey results.

Figure 4
Percent Reporting Written Policies Governing LDH/MCO Relationships by Policy Area and Respondent Group

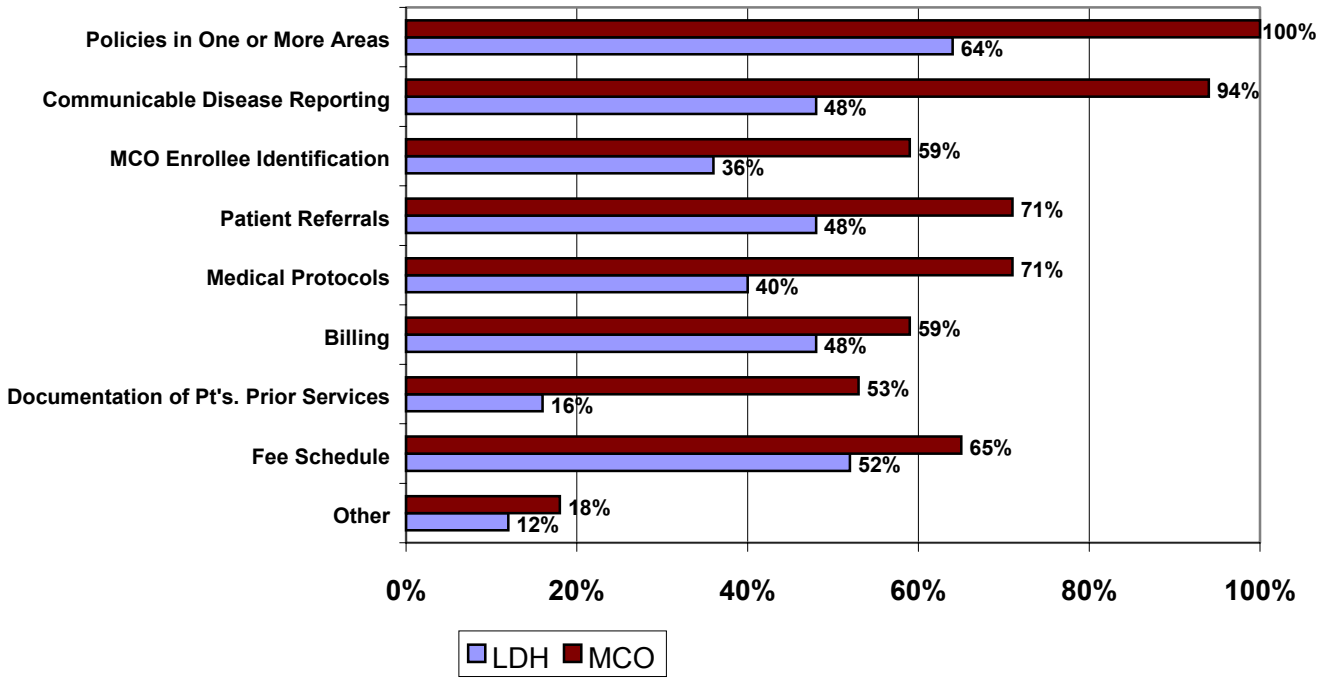


Figure #4 shows that 64% of the LDHs and 100% of the MCOs had reported written policies governing their collaborative relationships. For LDHs, fee schedule policies comprised the largest category (52%). For MCOs, communicable disease reporting was the largest category (94%).

Figure 5
Percent of MCOs and LDHs Reporting Staff Training in Policies by Policy Area and Respondent Group

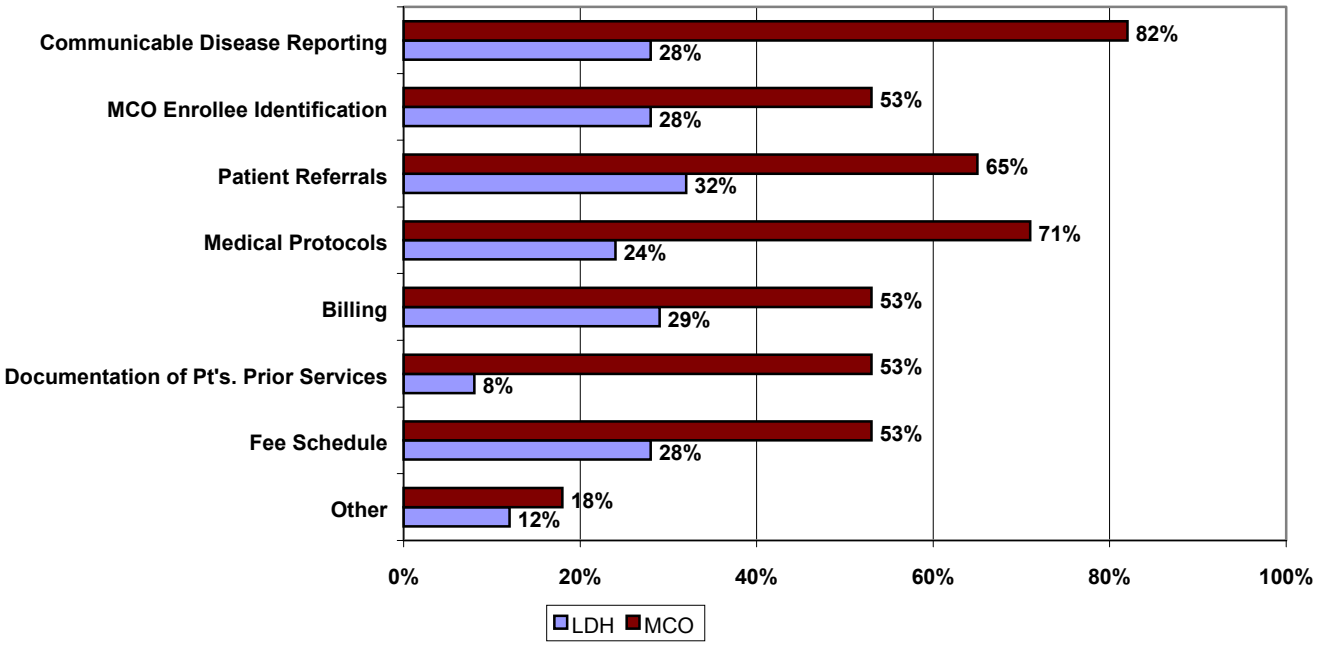


Figure #5 shows the extent to which the LDHs and MCOs conducted staff training in the policy areas shown in Figure #4. The largest percent of LDHs (32%) reported training in patient referral policies. The largest percentage of MCOs (82%) reported training in communicable disease reporting (82%).

Figure 6
Percent of LDHs Reporting System Infrastructure Measures to Work with MCOs

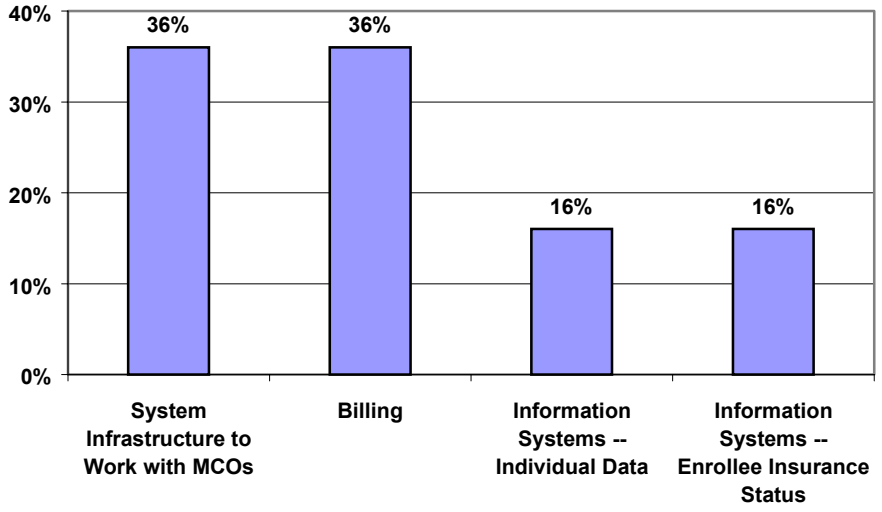


Figure #6 shows that 36% of the LDHs reported they had developed a systems infrastructure to work with MCOs. The largest category of infrastructure activity was billing (36%). Respondents who indicated they lacked a systems infrastructure were asked whether it was because the matter was a low priority or because there was a lack of sufficient technical resources. Responses were generally split between the two choices (Data not shown).

Figure 7
Percent Reporting Use of NYSDOH-Provided Data by Data Type and Respondent Group

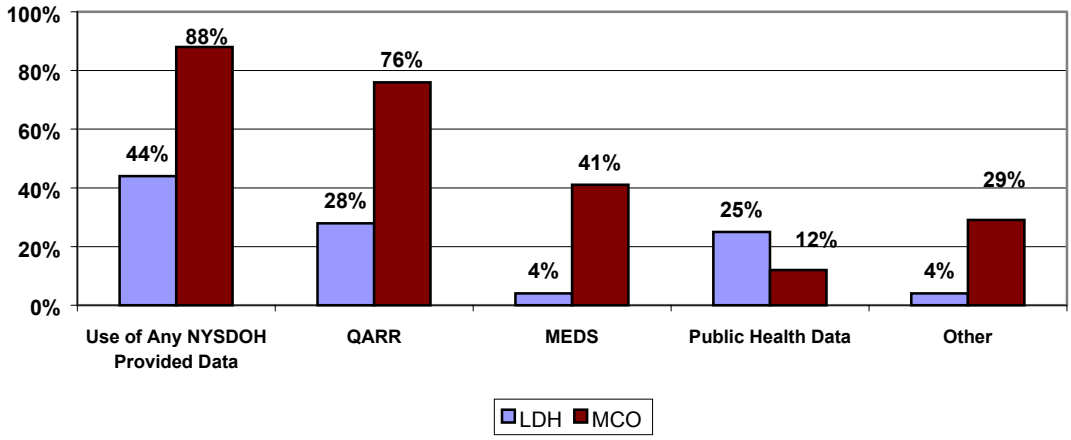


Figure #7 shows that 44% of the LDHs and 88% of the MCOs reported the use of SDOH data of any type. The largest category of data used, for both LDHs and MCOs was QARR (Quality Assurance and Reporting Requirements) – LDHs (28%) and MCOs (76%).

LDH/MCO Collaboration in Public Health Activities

Figure 8
Percent of MCOs Participating in LDH-Sponsored Education/Outreach and Community Assessment Activities by Respondent Group

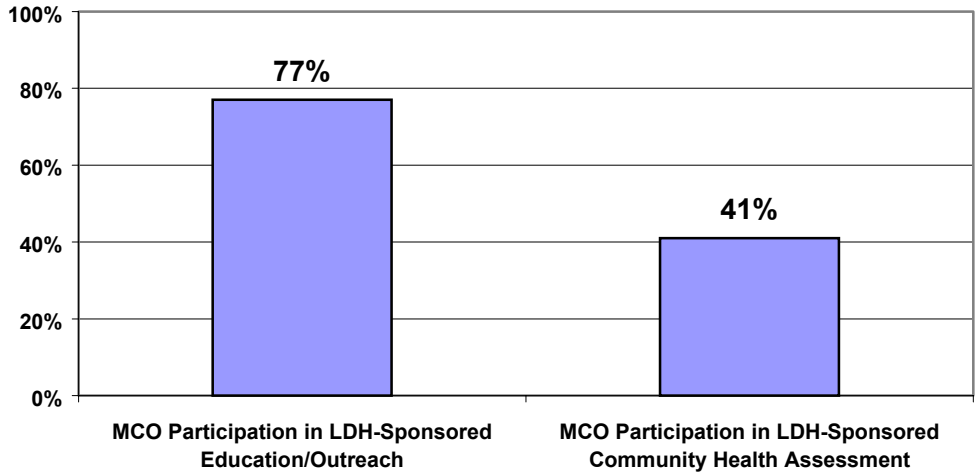


Figure #8 shows 77% of the MCOs reported participation in LDH-sponsored community education/outreach activities and 41% reported participating in LDH-sponsored community health assessment activities.

Examples given of MCO participation in community health education outreach campaigns included health fairs, informing providers about public health issues including immunizations, management of asthma and diabetes, HIV testing and counseling, smoking cessation, health education, and women's health (Data not shown).

Examples of MCO participation in LDH-sponsored community health assessment and planning included: health assessment and planning activities in breast cancer screening

and child health, general support to community assessment with staff or materials, participation in Healthy Community Initiatives, support for assessment and planning in specific public health areas: asthma, smoking cessation, immunizations (Data not shown).

Figure 9
Information Provided by LDH to MCO Network Providers and/or Enrollees

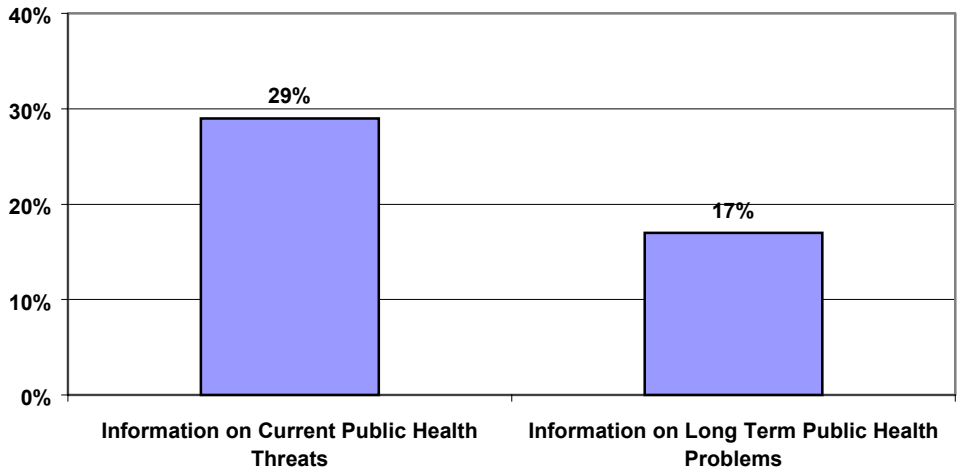
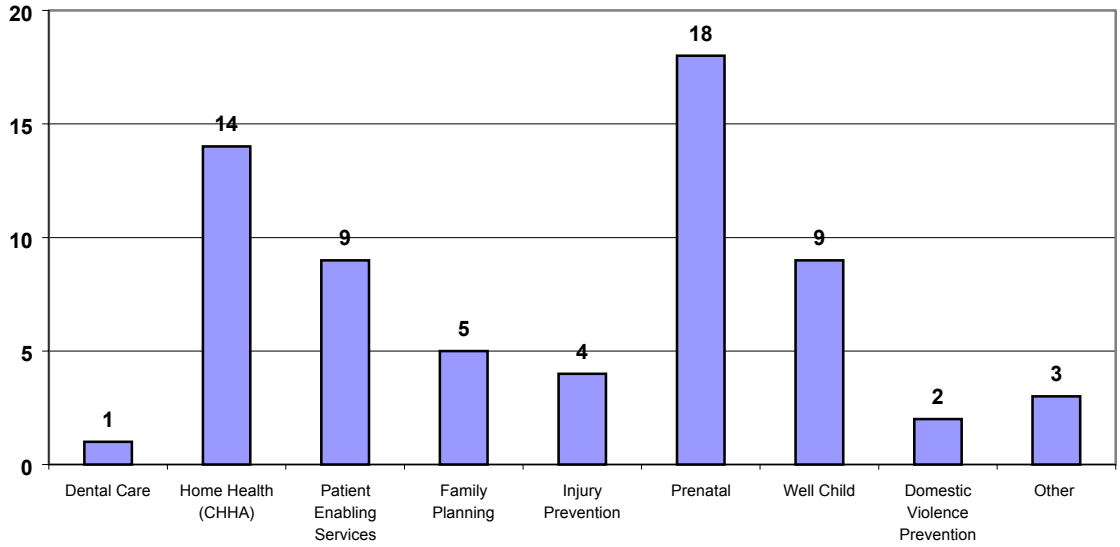


Figure #9 shows that LDHs distributed information to MCO network providers and/or enrollees on current public health threats (29%) and long-term public health problems (17%).

Figure 10
Number of MCO Contracts to Purchase LDH Services by Service Category



Approximately half (55%) of the LDHs reported contracts for MCOs to purchase LDH services for one or more types of services. Figure #10 shows the total number of contracts reported in each service area. Prenatal care was the largest area with 18 contracts reported.

Figure 11
Percent Reporting Efforts to Improve MCO Performance on Public Health Issues

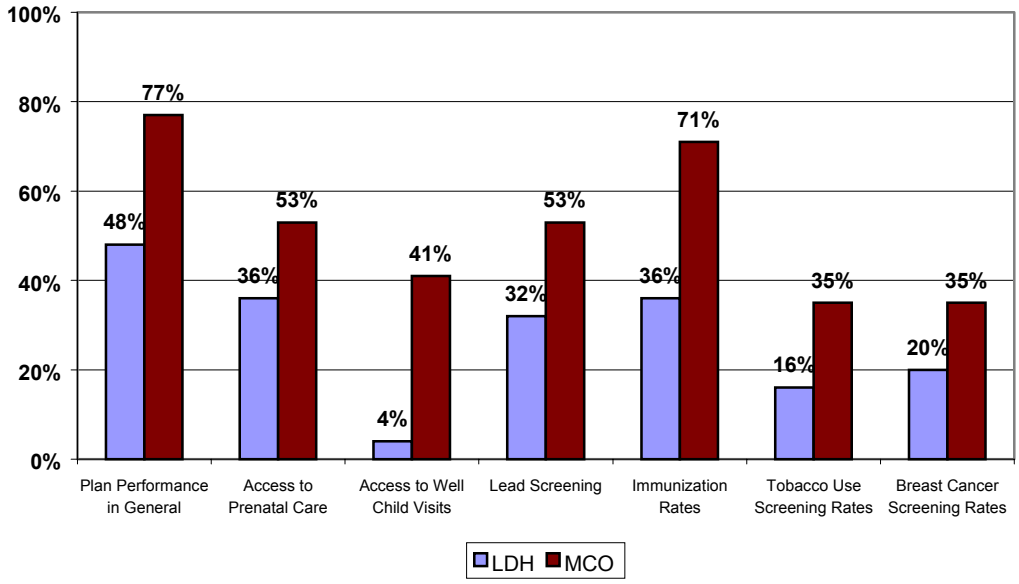


Figure #11 shows that 48% of LDHs and 77% of MCOs reported efforts by the LDHs to improve plan performance in one or more areas. Differences in the percentage of affirmative answers to a question by the LDH and the MCO regarding an event in common do not necessarily mean that the two groups have different views of that event. These differences can result from the fact that the number of MCOs that serve the Medicaid population varies widely by county. For the LDHs, the most important areas of effort to improve plan performance were access to prenatal care (36%) and improvement of immunization rates (36%). For the MCOs, the most important category of LDH effort was the improvement of immunization rates (71%).

Assessment of the Effectiveness of the Collaborative Process

Figure 12
Percent of LDHs and MCOs Rating Referral Procedures for Immunizations and Tuberculosis as Effective or Highly Effective by Respondent Group

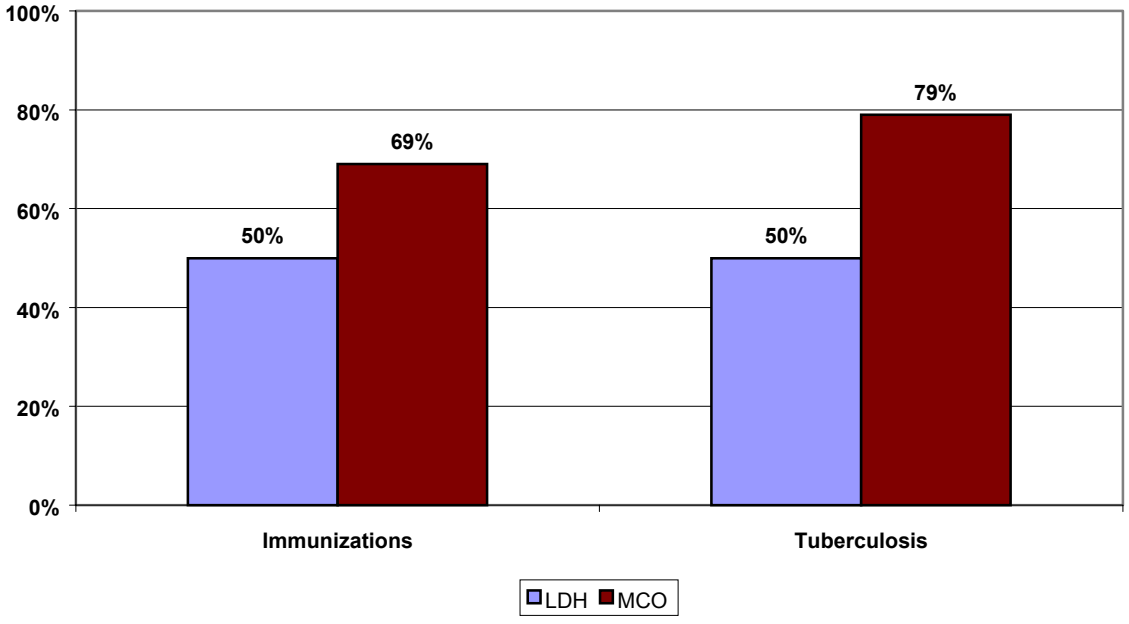


Figure # 12 indicates that referral procedures for immunization and tuberculosis were more effective for MCOs than for LDHs. MCOs reported the referral procedures were very effective or effective, with 69% for immunizations and 79% for tuberculosis

patients. Fifty percent of LDHs reported referral procedures for both immunizations and tuberculosis patients to be very effective or effective.

Figure 13
Percent of LDHs and MCOs Rating Reimbursement Procedures for Immunizations and Tuberculosis Effective or Highly Effective by Respondent Group

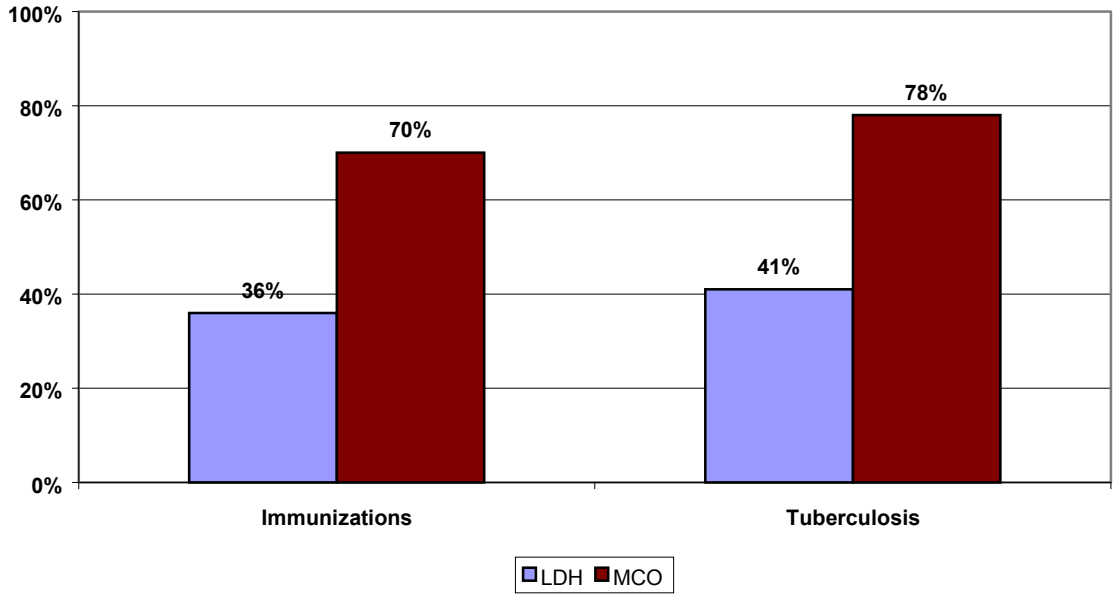


Figure #13 shows a similar pattern to Figure #12, with less than half of the LDHs expressing the view that reimbursement procedures for immunizations and tuberculosis were somewhat or very effective. A greater percentage of MCOs reported such procedures as somewhat or very effective, 70% for immunizations and 78% for tuberculosis.

Figure 14
Percent LDHs Characterizing their Relationships with MCOs, and MCOs Characterizing their Relationships with LDHs

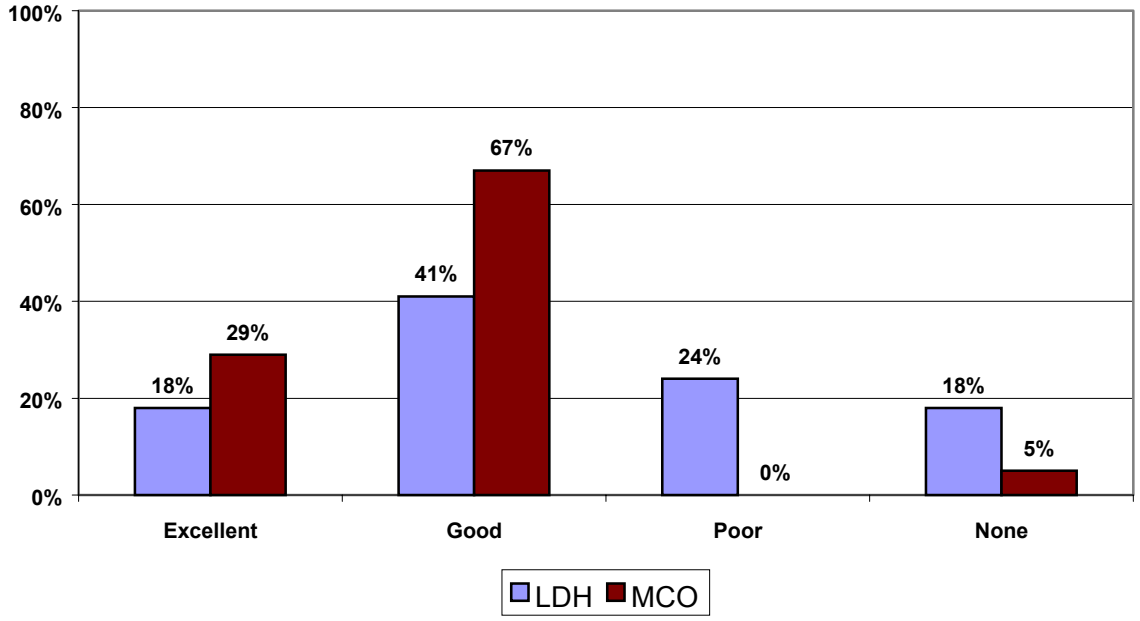


Figure #14 shows that 59% of the LDHs reported their overall relationship to be "good or excellent" with at least one MCO. Ninety-six percent of MCOs reported their relationship to be "good or excellent" with at least one LDH. Differences in the percentage of affirmative answers to a question by the LDH and the MCO regarding an event in common do not necessarily mean that the two groups have different views of that event. These differences can result from the fact that the number of MCOs that serve the Medicaid population varies widely by county.

Figure 15
Percent LDHs Reporting that MCOs Engage in Public Health Activities
By Level of Participation and Area of Activity

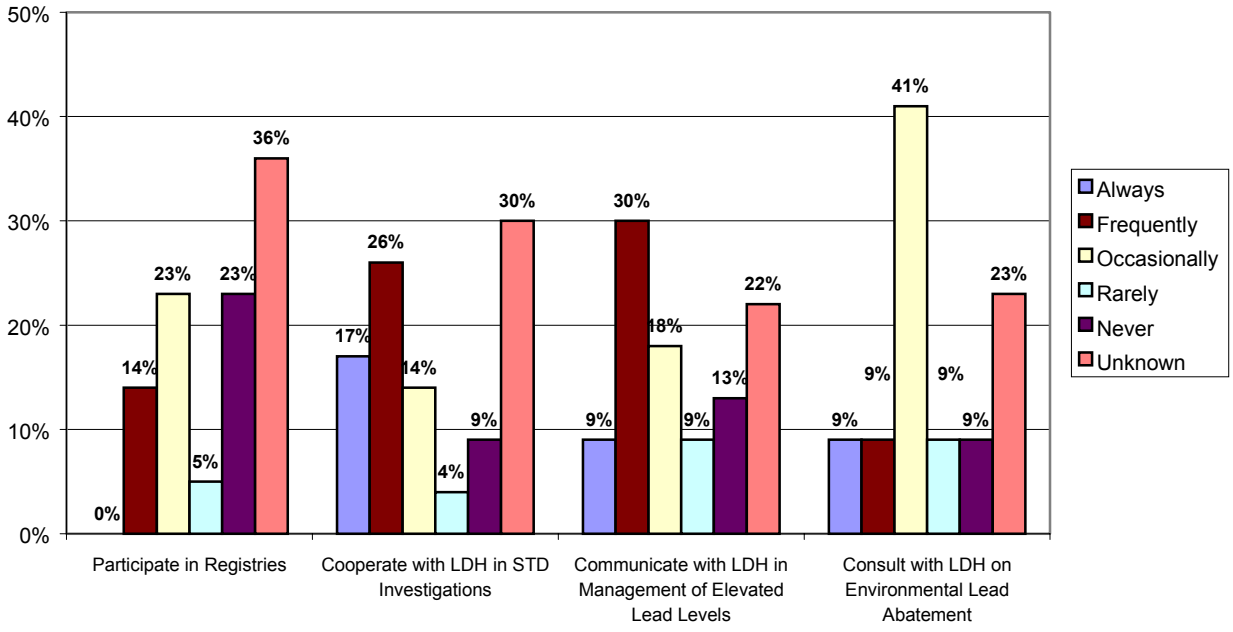


Figure #15 shows that for selected public health activities, the LDHs reported the lowest level of participation by the MCOs ("occasionally, rarely or never") in the area of consultation on environmental lead abatement (59%). It is possible that the responses may be measuring, in part, the frequency with which MCOs encounter problems in different public health areas rather than the level of collaboration. If such were true, it could mean that LDHs in counties where environmental lead abatement is a relatively less important problem, might report that MCOs collaborate on this activity less frequently than in other counties. Also, a substantial number of LDHs reported "unknown" regarding MCO participation in public health activities ranging from 36% to 23% depending upon the area of activity.

A similar concern is raised for the survey question asking LDHs to rate the degree of collaboration with MCOs in specified areas such as immunization, tuberculosis, and communicable diseases. The question appeared in the MCO survey as well. The intent of the question was to determine the level of collaboration between the LDHs and the MCOs, regardless of the frequency of interaction between them. Unfortunately, as

determined from the interviews, the respondents reported little or no collaboration between the LDHs and MCOs if activity in the public health area was infrequent, for example, in the case of rabies.

Figure 16
Percent LDSS Reporting Activities to Promote Collaboration between LDHs and MCOs by Area of Activity

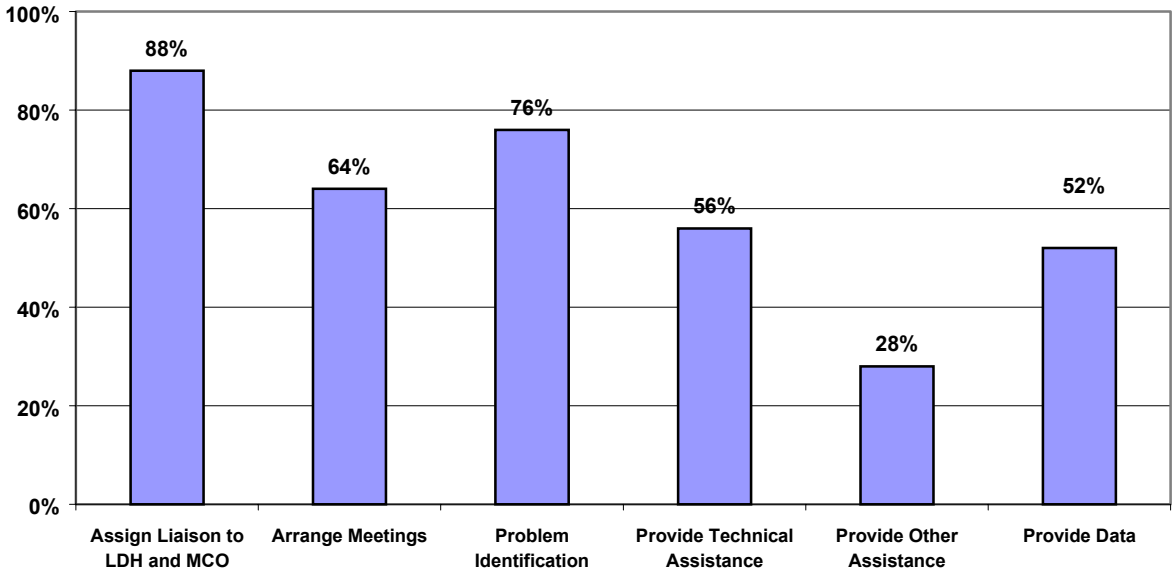


Figure #16 shows that with respect to LDSS activities to promote LDH/MCO collaboration, assignment of liaisons was the most frequently reported activity (88%).

Figure 17
Percent LDSS Reporting Involvement of LDH in LDSS Managed Care Activities
By Type of Activity

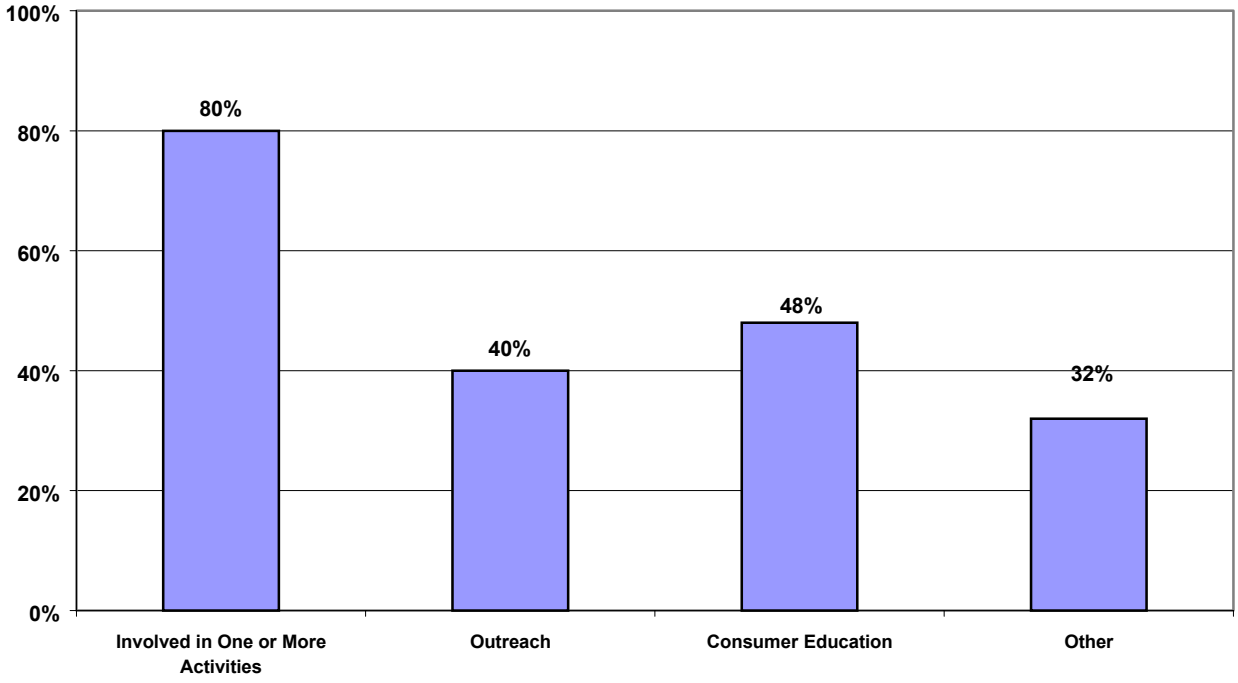


Figure #17 shows that in regards to LDH participation in LDSS managed care activities, the LDSSs reported 80% of the LDHs to be involved in one or more activity. The largest category of activity was consumer education (48%).

Open-ended Responses

The survey questionnaire included several open-ended questions on the factors that enhance or impede collaboration. The survey also asked the respondents to describe what measures could be undertaken at the county level or by the SDOH to foster collaboration. There were not enough responses that were consistent enough to group into categories and tabulate. Also, given the brevity of many of the responses, their meaning was not always clear. Several of the themes covered in the open-ended responses were used to formulate the questions for the in-depth interviews. (See Appendix F.)

Interview Results

Background

Twenty-three interviews were conducted between October 9, 2001 and November 26, 2001. A list of those interviewed appears as Appendix E. The majority of interviews were conducted in-person. In five cases, because of logistical problems, the interviews were conducted by phone. All interviews were conducted by the lead author of the study. Two parties declined to be interviewed.

The goal of the interviews was to obtain a more in-depth understanding of the principal areas covered in the mail survey: 1) the activities through which collaboration between the LDHs and MCOs takes place, 2) the factors that promote or impede collaboration and, 3) suggestions to the SDOH on ways in which it might promote LDH/MCO collaboration. Prior to each interview, the responses to the written survey were reviewed with particular attention paid to strongly negative or positive responses and to responses that showed substantial differences of opinion among respondents in the same county. Where available, the websites of the respondent organizations were also reviewed in preparation for the interviews.

At the interview, the respondents were informed that all information from the interviews would be reported in aggregate form only, and that there would be no ability for responses to be linked to any individual or organization. While this approach helped to create an atmosphere for more candid responses, of necessity, it forced the presentation of the data to be more general.

The interviews were scheduled for 45 minutes but most lasted for about an hour. The original plan was to ask a standard set of questions of each respondent and then tabulate the responses. However, after the first few interviews, it became apparent that it was not feasible to ask all interviewees the same questions. If this had been done, there would have been little time to explore the specific issues and experiences that were important to

the respondents. It should be understood that the issues presented below were important to at least one respondent. The absence of comments on a particular issue, however, should not be taken to mean that the issue was unimportant. Rather, the issue was of lesser importance but would have been raised if additional time were available.

The interview responses with respect to the process of LDH/MCO collaboration have been organized into three broad categories: 1) structural issues; 2) operational issues; and 3) organizational goals, roles, responsibilities and expectations. In addition, there are sections describing: 1) other factors influencing the collaborative process; 2) models and best practices; and 3) recommendations from the respondents to the SDOH.

There is some overlap between the three categories used to group responses. For example, the lack of a system for communicating immunization information from the LDH to the MCO may exist because of a lack of compatibility between the LDH and MCO reporting systems (structural issues). It may also be due to the fact that it is not high on the list of priorities for the LDH (organizational goals, roles, responsibilities and expectations). Finally, it may be caused in part by personality differences between the parties (interpersonal relationships and attitudes).

Interview Findings

While the findings below provide more information about the written survey results, the issues below cannot be interpreted to characterize all MCO/LDH relationships. It is also important to understand that some LDHs, MCOs, and LDSSs responses may reflect individual perceptions and may not always accurately reflect New York's public health and Medicaid managed care requirements and systems.

1. Structural issues

This category refers to administrative arrangements, policies, procedures, and practices that affect the interactions of the LDH and the MCO in advancing the public health

agenda. It also includes events and activities outside of the LDH/MCO arena that impact the relationship between the two parties.

- ***Information systems***

  Many of the respondents focused on problems in communicating patient financial and clinical information between LDHs and the MCOs.

  The root of the problem differs from county to county. One county had only recently begun to participate in Medicaid managed care and the LDH was just beginning to address the need to develop the information systems required to send financial and clinical information to the MCOs. The LDH official stated, "In retrospect, we probably lost an opportunity to get ready for mandatory Medicaid managed care." While many of the MCOs expressed frustration with the delay in getting claims for payment from the LDHs, they were also concerned about the gaps in clinical information that frequently arise. Comments from the MCOs included the following, "The only way we know if the child got his immunizations at the health department is if we see a bill. In some cases the bills are two or three years old." "If a woman enrolled in my plan gets a pap smear as part of a family planning visit to a health department clinic, it would be nice if the department had a way to tell me. I could save time by not having to chase after her to get a pap smear."

  Patient information flow from the SDOH to the MCO was also cited by one plan as a problem. The respondent mentioned that in the case of carve-out services, the bill for the services is sent to the state. Therefore, in principal, the state should be able to provide the clinical information back to the MCOs on the patients served but this is rarely the case. As an example, she stated that she has never seen any report from the state concerning lead testing results of enrollees.[3]

[3] While lead tests are a managed care benefit, lab reports of test results are routinely sent to the LDH.

- ***Policies, rules, regulations***

  One MCO that serves a large multiple-county area remarked that, "Given the same public health initiative (e.g. Domestic Violence), each county has its own unique program requirements and ideas as to what constitutes an effective program. For an MCO that spans multiple counties, it is difficult to develop and maintain a program that meets the requirement of each of the individual counties."

  A few of the MCOs criticized the requirement that the MCOs must include the LDH in its provider system. As one plan official put it, "This requirement puts us at a competitive disadvantage in negotiating with the county health departments since they know we can't walk away from the table."

- ***Formal arrangements for collaboration***

  Most counties had some kind of formal structure for collaboration between the LDH, the MCOs and the LDSS. It was clear that in some areas the structure works better than others. One example of an apparently effective structure is a "human services cluster" that meets under the auspices of the county executive. This arrangement includes the LDH, LDSS, the county mental health department and other human services agencies. Medicaid managed care issues are discussed in this forum.

  In several counties there are formal meetings between the LDH, LDSS and the MCOs, typically in the form of advisory committees, although in more than one county the activities of the committees were described as "dormant" or "off and on." Managed care plans, for their part, described many areas and avenues of communication with the LDHs but these were more often on a one-on-one basis rather than through a committee involving the county's MCOs, the LDH and the LDSS.

  One respondent cited the Western New York Public Health Coalition as an example of collaboration between the MCOs and the LDHs. The coalition involves the MCOs and the LDHs in eight counties. One activity cited was the education of network

providers by the coalition concerning the services available through the LDHs. Information about the LDHs is communicated through the Coalition's monthly newsletter of the coalition.

According to an LDSS respondent in one county, the LDSS meets monthly with the MCOs. In that county there is an advisory committee for the Medicaid Managed Care Program, which includes the LDSS, LDH, MCOs, several private physicians, the County Department of Mental Health, school superintendents, and representatives from the four hospitals in the area. The advisory committee was dormant for a while but has been recently re-activated and met in July and September of this year. Topics of the advisory committee meetings have included the Child Teen Health Plan; the responsibilities under mandatory Medicaid managed care compared to the voluntary program; and Family Health Plus.

In one upstate area, an initiative involving a broad coalition of parties was formed to implement facilitated enrollment. Currently, the initiative operates in five counties and involves the five LDHs, the five LDSSs and all of the MCOs that serve the five counties. As a by-product of this initiative, the counties have now become more flexible with respect to their boundaries, all in the interest of providing more continuous care to clients when they move.

In another county there is a managed care coalition consisting of the LDSS, the LDH and the MCOs that meets every two months. The parties are involved in a cooperative effort that focuses on the prevention and management of asthma. They are also involved in a "Too Smart to Start" group that targets elementary school children with smoking prevention messages.

- ***New demands from a changing environment***

  A few respondents commented that the public health role and MCO/LDH cooperation was going to be closer as a result of the terrorist attacks of September 11, 2001. Possible future activities such as mass screening and mass distribution of antibiotics

will have to be planned and executed by the LDH and MCOs in a coordinated way. One MCO official mentioned that it is absolutely essential for the MCOs and the LDH to speak with a single voice regarding the policies for identifying and treating victims of a bioterrorist attack. To do otherwise would result in widespread confusion and anxiety.

2. Operational issues

This category refers to operational limitations or inefficiencies that impact on the process of LDH/MCO collaboration. Several respondents commented that burdensome requirements and administrative inefficiencies, even if they do not directly relate to issues that involve LDH/MCO collaboration, nevertheless take away valuable time that could be devoted to developing cooperative programs and relationships.

- ***Resource limitations***

  Some LDHs acknowledged the desirability of the plan serving as a source of primary care services to Medicaid enrollees, but in at least one case the LDH had not developed the systems for sharing clinical and financial information with the MCOs because of resource limitations. One LDH respondent remarked, "We have been asked to provide more information to the MCOs, but have not been given more resources to do it." Another LDH respondent stated, "Immunization and tuberculosis services are a small part of the services we provide. It isn't really worth it to set up system to track and bill for services that we don't provide in volume."

  In one case, an MCO respondent described an initiative to provide asthma services in the schools that involved collaboration between the plan, the school based health center program, the board of education, and community organizations. The project was submitted as a grant proposal but was not funded. Notwithstanding, the plan decided to proceed with the program anyway. The MCO purchased peak-flow meters for the schools so they could monitor asthmatic children. However, effectively addressing the asthma problem also involves dealing with environmental triggers of asthma attacks, for example, acquiring and using special mattress covers. This went

beyond the scope of services that could reasonably be provided by the plan, and there were no other public or private resources available for that purpose. The respondent indicated there were a lot of similar, worthwhile projects but their implementation was limited due to a lack of resources.

- ***Facilitated Enrollment Activities***

  Facilitated enrollment into Child Health Plus and Family Health Plus was seen as resulting in increased communication between the MCOs and the LDHs because county health departments and managed care plans both function as enrollment agents for the programs.

3. Goals, roles, responsibilities, expectations

Effective collaboration is furthered when the parties have compatible goals and a shared understanding of their roles and responsibilities. While the written survey and best practices suggest an array of collaborative activities undertaken by LDH, MCOs and LDSS, some respondents identified a few examples where incompatible goals and role confusion were barriers.

- ***LDH as a direct service provider***

  In some cases, an important barrier to collaboration was the lack of alignment of the strategic goals of the three involved parties. Where the LDH was reluctant to relinquish its direct care responsibilities to MCOs, then collaboration between the two parties was going to be impeded. In one case, the LDH appeared unwilling to accept the new reality that managed care patients who had previously come to the LDH for immunizations and other services, were now to go to their primary care physician in the MCO network for these services. There was an apparent reluctance on the part of the LDH to accept the fact that it might no longer be able to continue its role as a resource to the general public. As stated by one LDH respondent, "We are a county-wide service available to everyone. We immunize doctors' children." Another example of the misalignment of LDH and MCO goals was given by an LDSS official

who said, "There are now plenty of dentists available to serve Medicaid managed care enrollees in the county, so why does the LDH still have dental clinics?"

One LDH official, while acknowledging that MCOs faced a difficult challenge in working with the Medicaid population, pointed out that if MCOs were really doing their jobs, their enrollees would not be going to the LDH for services. "Of course it is not easy for plans to change patient behavior, but the plans need to understand the importance of patient education, outreach and making the services accessible to the Medicaid population."

- ***The preventive health mission***

  Some LDH respondents believe that there is a lack of congruity between managed care goals and the preventive health mission to some extent. One LDH official said "Let's face it, from the point of view of the plans, preventive services are not a good business investment. If the average Medicaid enrollee is with a plan for 6 months or a year why should the plan invest in preventive services for example, exercise, diet, smoking cessation, if the benefits won't be received for 20 years?" That official added however, that he had been able to involve the plans in prevention services by focusing on those preventive activities that have a more immediate effect such as smoking cessation for pregnant women, and measures to reduce hospitalizations for asthma, or uncontrolled diabetes.

  At the same time, there are examples where the LDH/MCO prevention and public health goals are well aligned. As one LDH respondent noted, some MCOs are more "public health oriented" than others. One LDH respondent remarked: "Some plans are quite willing to reimburse the LDH for Hepatitis B vaccinations (which are now required for all school age children by the seventh grade). For others it's like pulling teeth." Similar examples were given with respect to the variation among plans in their willingness to approve home visits for families that display significant problems in areas such as delayed entry into prenatal care, family violence, and drug or alcohol abuse. One LDH described a plan with which it had a good working relationship as

"understanding that the LDH can actually help the MCO fulfill its mission and help the bottom line of the plan." Better QARR (Quality Assurance and Reporting Requirements) and HEDIS (Health Plan Employer Data and Information Set) results can be obtained with cooperation from the LDH and this also helps the plans."

In a similar vein, another LDH representative said that originally one of the plans serving Medicaid recipients in the county did not want the LDH to provide immunizations, preferring that they all be done by the plan. When the QARR report indicated the MCO was deficient in its immunization rates, the plan changed its policy and encouraged the LDH to immunize children when the opportunity presented itself. QARR rates subsequently improved, to the satisfaction of all parties.

One LDH official expressed frustration at the fact that many MCOs do not see it as part of their mission to share information with the LDH on community health issues. She felt that MCOs have a wealth of information that could be a great value to the LDH in its community assessment process. For example, MCOs would be able to know whether there was an unusual level of emergency room visits, or increased incidence of domestic violence or injuries on the part of the managed-care enrollees. Knowing this information might enable a more effective targeting of preventive services by both the plan and the LDH. The respondent added that MCOs should not only provide information but also actively participate in analyzing that information and developing community-based action plans to address the problems.[4]

- ***The MCO as a business organization vs. the LDH as a public agency***
  Several MCOs suggested that the LDHs often operate with a different mind set from the plans. As one MCO respondent put it, "The county health department doesn't realize we are a business. We cannot operate at a deficit. Already two plans in this county have gone out of business. The county department of health often asks us to

[4] LDH are required to conduct regional community health care assessments. NYSDOH Medicaid managed care public health guidelines list MCO participation in community health assessment as an area for potential collaboration.

pay for home-visiting services that are not really for medical problems. Why are we being asked to pay for the home visiting in a family abuse problem? Where are the other social agencies?"

- ***Perceptions concerning responsibility to "fix" the Medicaid system***

  There was a general view expressed by the plans that unrealistic expectations for improving the Medicaid system had been set for them by the SDOH and, by extension, the LDH. In the MCOs' view, even if funding were adequate, there would still be major challenges to changing patient and physician behavior in such a way as to make the Medicaid system work to maximum efficiency. As one MCO respondent stated, "For the past 30 years, the fee-for service Medicaid program was barely able to achieve an immunization rate in excess of 40 percent. Our plan achieved an 85 percent rate and yet the NYS Department of Health cites us for not achieving a 90 percent rate. [5] How much control does the state think we have over Medicaid clients, almost all of whom have major needs for social and support services?"

  Many of the MCOs expressed resentment at having to monitor their providers on matters that the plans felt should be primarily the responsibility of the LDH. A typical comment was "The health departments could never get the private physicians to report communicable diseases adequately and now they are telling us (the plans) that it's our responsibility. The health department says we have financial leverage over the providers but, realistically, how much leverage do we have if a physician is enrolled in five or six plans?"[6]

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[5] New York State Department of Health does not cite plans for failing to achieve a 90% Immunization rate. The Department has a quality improvement focus. Each year plans are compared to the statewide MCO average rate for immunizations and other health outcome indicators. Plans with rates below statewide averages are asked to develop corrective action plans.

[6] NYSDOH expects Medicaid MCO to make reasonable efforts to assure provider compliance with communicable disease reporting. However, it should be noted that since this survey was completed, the state and LDH have initiated a number of activities to improve communicable disease reporting in response to the threat of Bio- terrorism. These activities involve many health care system participants, including providers.

Another plan stated that it had no legal authority to force corrective action on the part of providers or laboratories that fail to comply with mandatory disease reporting. One plan respondent stated, "In the case of reporting from clinical laboratories that serve the plan, the notion that the MCO dollar will influence laboratories' behaviors is ridiculous. We have to beg the laboratory for service. Also, they are located in Pennsylvania, which makes it even more unlikely that the plan will have any clout.

According to one plan, the SDOH audit of the plan's asthma and prenatal services found that only 10% to 15% of the providers were in compliance with guidelines. As the plan medical director reported, "When you have only 10% to 15% of the providers following a practice guideline, that is a failure of physician practice patterns, not a failure of the managed care plans."

- ***The role of the LDH as a monitor of the MCO[7]***

  Two plans referred to the potential conflict of interest that exists when a LDH assumes the role of both a monitor of MCOs and a provider of services. "It puts the plans in a difficult position to say 'no' to a health department if the department points out to a plan that the QARR showed the plan was deficient in maternal and child health services, and then the health department says 'By the way we have maternal and child health outreach workers here whose services you could use, for a fee.'"

  One plan commented on the inherent tension between the LDH role as a monitor and as a partner. "It's hard to be both an enforcer and a collaborator."

  Another plan stated, "In general, the LDH is seen more as a regulator than a collaborator. Ideally, if the LDH were a true collaborator, it would provide education and assistance. The advantage of collaboration with the LDH is not so much the technical expertise it has to offer as it is acquiring the knowledge that the LDH has about its region and its providers."

[7] LDH has responsibility for core public health functions for the entire community, but does not have direct responsibility to monitor the quality of services provided by MCOs. This is a SDOH responsibility.

Another view expressed by the plan was, "There is a lot of variation among the counties with respect to the involvement of the LDH and the managed care plans. In some counties the LDH operates as a policeman; in other counties, the LDH takes a more collaborative approach.

4. Other factors influencing collaboration

Experience with managed care was a factor cited as influencing the collaboration process. Some plans stated that in counties where managed care had been present for a long time, there was good collaboration. In counties that had only recently begun to serve Medicaid enrollees, collaboration was less well developed. In such situations, some plans suggested resurveying them six months later about their collaboration with the LDHs, implying that it would be better then.

LDSS, LDH and MCO respondents found that interpersonal relationships and attitude affected the outcomes. Respondents identified leadership, staff who understood public health and managed care, participatory management style, flexibility, and willingness to listen as important to successful collaboration. In particular, respondents identified the support and leadership of the LDSS as important. All three types of respondents provided examples where negative attitudes and poor understanding of public health or managed care delivery systems and issues produced poor cooperation between the programs and negative results.

As noted by several plans, LDHs varied widely in their size and scope of activities. As several respondents indicated, there tended to be less collaborative LDH/MCO activity in counties where the LDH provided few direct patient care services.

The form of managed care in a particular county also affected the MCO/LDH collaboration process. One county was described by the LDH respondent as "managed care light", i.e. managed care was delivered primarily through Individual Practice

Associations (IPAs) rather than staff model HMOs. As a result, the respondent indicated that the LDH tended to talk directly to physicians rather than through the plans on any matters of importance to the LDH. He stated that this might be different if the dominant form of managed care were the staff model HMO, which has an administrative structure that relates to the physicians. When asked if he thought that the MCOs might be able to provide some assistance to the department in gaining provider compliance with reporting requirements, he expressed agreement with the idea.

5. Best Practices

There were numerous examples of programs that showed effective collaboration between the LDH and the MCO. The more notable ones are mentioned below.

- Several counties had significant collaborative activities focusing on high-risk pregnancies. Typically, these activities involved outreach workers or nurses who conducted home visits and provided education on prenatal care, smoking prevention and/or cessation, and child rearing.

- One county had a diabetes coalition that involved the MCOs, the SDOH, the LDH, the Academy of Family Practice, and the American Diabetes Association. The coalition provided toolkits for primary care physicians including stickers for charts to indicate which patients had diabetes treatment guidelines and flow sheets to track the treatment process. Providers also received a diabetes management newsletter.

- One innovative project focused on improving provider immunization rates and the reporting of those rates to the LDH immunization registry. The project involved the plan paying $20 to the provider for each patient for whom the provider gave evidence that the patient's immunizations were up-to-date and properly reported. This incentive allowed the plan access to the physician and made the physician more aware of the importance of reporting immunization information. The respondents stated that they did not yet know for sure the results of this incentive program but that preliminary evidence suggested it was working.

- The LDH in one county joined with a health plan to provide each new mother a $40 dollar gift certificate for a visit to a hairdresser if the mother completed all of her postpartum visits. The LDH coordinated this initiative with the MCOs. The LDH respondent indicated that the project had definitely increased the postpartum visit rate of new mothers.

6. Suggestions for the SDOH

A few MCOs said the SDOH should provide more county-specific data on the performance of plans. Currently, some managed care quality assurance reports are designed to measure plan performance. Since many of the MCOs operate in more than one county, the data is not county specific. Thus, LDH is unable to determine how well a plan is performing in their county.

Several respondents felt that the SDOH should serve as source of accurate, complete, and current information for the LDH, LDSS, and the MCOs. They suggested forums in which that sharing of information could occur, including an SDOH-sponsored conference to present best practices and to share information on collaboration models. Other topics suggested for the conference included improving the sharing of data for community health planning; developing technical support in computerizing the practices of network providers to improve efficiency, quality of care, and the sharing of data by electronic transmission; communicating the priorities of the SDOH with respect to managed care and public health; clarifying eligibility rules for special programs such as Early Intervention and for carve out programs; and developing more uniformity in the requirements for LDH/MCO collaboration.

One LDSS suggested that it might be best for local government to get out of the Medicaid managed care business altogether and leave it to the SDOH. "Currently the State sets reimbursement rates and determines what's in the contracts for Medicaid, Child Health Plus, or Family Health Plus. Before, when the County was initiating the mandatory Medicaid managed care system, the LDSS issued the RFPs and was directly involved in

the negotiation process. Now the situation is quite different."

The SDOH should support the role of the local SDOH regional office as a resource to the LDH and the MCOs.

Several respondents expressed concern at the delay in getting contracts approved through the state system. As one plan respondent put it "The State never hesitates to hold the MCOs to deadlines but never applies the same principles to itself." The pressures and administrative burdens that arise because of delays in contract approval may detract from the time that MCOs could be devoting to collaborative activities with the LDH.

Some MCOs also expressed the desire for the SDOH to reexamine the requirement that the MCOs negotiate with the LDH for services. The MCOs felt that they were put at a competitive disadvantage in such negotiations because the LDH could simply wait until the MCO was forced to agree to the LDH's terms.

One LDH suggested the SDOH should focus more on improving the quality of care received by Medicaid enrollees and less on the specifics of the collaboration between the MCO and the LDH.

Many of the plans suggested that the SDOH ensure that the MCOs receive more consistent reimbursements tied to the actual costs of providing services to Medicaid enrollees.

A few MCOs and an LDH suggested that the SDOH use its disciplinary authority over physicians (sparingly) to get compliance with respect to disease reporting. The SDOH, not the LDH or MCOs, is the only agency with the power to suspend or revoke a physician's license.

Summary of Findings

This was an exploratory study that sought to examine the nature of LDH/MCO collaboration and the lessons that could be learned from the collaborative experience to date. The study is a beginning, and findings should be considered preliminary, subject to modification as further discussion of the issues takes place.

1. **A system of written agreements appears to provide a framework for interaction between MCOs, LDHs, and LDSSs.**

   With the exception of two counties, all counties surveyed had formal written Medicaid managed care public health agreements. The Memorandum of Agreement was the most frequently reported (52%) form of agreement between the LDH and the MCO. In twenty-eight percent of the surveyed counties, the agreement was an appendix to the Medicaid managed care contract. The majority of the LDHs, MCOs, and LDSSs reported activity related to the public health agreements. The majority of the LDH and MCO respondents reported designating liaisons to work with other agencies, attending one or more public health managed care related meeting(s) in the last 12 months and having written internal policies/staff training for at least one area critical to LDH/MCO relationships (e.g., communicable disease or patient referrals). The majority of the LDSSs reported arranging meetings, assisting in identifying problems, and providing technical assistance.

2. **The LDHs and MCOs reported working together on specific public health issues**.

   Seventy-seven percent of MCOs reported participating in LDH sponsored community education/outreach activities and forty-one percent of MCOs reported participating in community health assessments. Seventy-seven percent of the MCOs reported working with LDHs to improve their plan's performance on public health measures. The MCOs identified immunization rates as the most common plan performance area for LDH/MCO collaboration. Although the percentage rates are lower, LDHs also reported MCO participation in education/outreach activities (forty-four percent), community health assessment activities (twenty percent), and working with MCOs on plan performance (forty eight percent).

3. **There appear to be several examples of successful collaborations.**

   In the written survey, all but one of the MCOs reported a good or excellent relationship with at least one LDH and fifty-nine percent of the LDHs reported a good or excellent relationship with at least one MCO. The interviews identified encouraging examples of increasing alignments of LDH/MCO interests. Several counties reported collaboration on high-risk pregnancies. One county had a diabetes coalition that involved MCOs, SDOH, the LDH, the Academy of Family Practice and the American Diabetes Association.

   Respondents identified several factors that led to successful collaborations**.** LDSS, LDH and MCO respondents found that interpersonal relationships and attitude affected the outcomes. Respondents identified leadership, staff who understood public health and managed care, participatory management style, flexibility, and willingness to listen as important to successful collaboration. In particular, respondents identified the support and leadership of the LDSS as important.

   Counties that had formal existing structures for collaboration in other areas seemed to have an advantage. In several counties, the three agencies already had regular

meetings. Some interview participants indicated that facilitated enrollment in Child Health Plus and Family Health Plus led to increased LDH/MCO communication. There were multi-county coalitions that MCO respondents with contracts in several counties identified as effective. Study respondents also indicated that positive outcomes from one collaborative effort promoted future efforts. Finally, a few respondents commented that the need to respond to bio-terrorism might promote greater need to coordinate LDH and MCO activities.

4. **Both MCOs and LDHs identified problems and areas requiring improvement.** While the majority of LDHs, MCOs and LDSSs reported successful examples of collaboration, there were LDHs and MCOs without liaisons, regular meetings, internal policies, and staff training or collaborative public health activities. Many of the respondents focused on problems of communicating patient financial and clinical information between LDHs and MCOs. MCOs reported problems with timely LDH claims and clinical information. LDHs identified referral procedures and reimbursement for tuberculosis and immunizations as problematic. In the written survey, only thirty-six percent of the LDHs reported having the necessary infrastructure to communicate financial or clinical information to MCOs.

   Some MCOs reported concerns about unrealistic expectations of an MCO's ability to address public health problems that may require the coordinated efforts of a number of players. In particular, MCOs mentioned communicable disease reporting as an area where changing provider reporting behavior would require more than just MCO action.

   The respondents identified a variety of factors that impeded the collaboration process. All three types of respondents provided examples where negative attitudes and poor understanding of public health or managed care delivery systems and issues produced poor cooperation between the programs and negative results. Although there were examples of LDHs and MCOs working towards a common goal, some LDHs and MCOs mentioned the difference between public health and managed care

goals/missions as problematic. According to some respondents, the county's experience with managed care may also affect MCO/LDH collaboration. MCO interview respondents stated that collaboration was less well developed in counties that had only recently begun to serve Medicaid enrollees. Role confusion was also identified as a factor. Respondents mentioned the potential conflict of interest that exists when an LDH assumes the role of both a monitor of MCOs and a provider of services and concerns about LDH willingness to relinquish the direct provision of health care services to the MCOs. MCOs with multi-county contracts created challenges for the collaboration process. MCOs found the different LDHs' policies administratively difficult and LDH found working with corporate offices outside of the county problematic. Another factor that could impede LDH/MCO collaboration was when the LDSS did not consistently serve as an advocate for the enrollee with both the LDH and the MCO.

All three types of respondents identified larger system issues that limited their ability to assure community access to quality health and public health services. Not directly related to the managed care public health agreement process, these issues included the complex array of publicly funded health programs, limited resources, and changes in health coverage. Some LDH claimed that the turnover of Medicaid patients enrolled in a plan created a major disincentive for the plan to provide preventive services and made local coordination of services difficult.

5. **Both MCO and LDH respondents reported using data provided by the SDOH in the collaboration process.**

   Not surprisingly, the MCOs were more active users of the two managed care related reports: Quality Assurance Reporting Requirements (QARR) and Medicaid Encounter Data Systems (MEDS) and LDHs were more active users of New York State Public Health data. Both LDH and MCO respondents were interested in better ways to share clinical and public health data. In particular, both asked for county level data.

6. **While not required by SDOH as part of the public health agreements, a significant number of LDHs have agreements with MCOs to provide health care services.**

   Fifty-five percent of LDHs reported contracts with MCOs in the service areas of home health, family planning, prenatal care, domestic violence, etc. Prenatal care was the most common contracted service with eighteen LDHs reporting MCO contracts for the provision of prenatal care. Consistent with a national trend observed since the late 1990s, LDHs in NYS are transitioning their direct delivery services to other providers and refocusing resources on more population-based services.[8] Fifty-six percent of the LDHs reported reducing their delivery of health care services such as well child clinics. Seventeen percent of the LDHs reported providing new enabling services, such as outreach worker assistance in Child Health Plus and Medicaid enrollment. One LDH reported increasing responsibility in coordinating services for Medicaid managed care enrollees.

Recommendations

1. **SDOH should continue to require that Medicaid and Family Health Plus MCOs have agreements with LDHs.**

   While the existing written agreements do not necessarily guarantee collaboration, the agreements have created an opportunity and a format for collaborative activities. SDOH should provide technical assistance and training where appropriate to ensure that all parties have an understanding of the purpose and intent of the agreements. In particular, SDOH should provide training and technical assistance to counties where significant Medicaid managed care enrollment is relatively new.

2. **SDOH should create a forum for sharing best practices.**

   The array of collaboration activities undertaken by LDHs, MCOs and LDSSs is impressive and reflects a wide range of local conditions and diversity of

[8] National Association of County and City Health Officials, *Local Public Health Agency Infrastructure, A Chartbook,* October, 2001. P.18.

organizational arrangements. All but one of the MCOs reported a good or excellent relationship with at least one LDH and 59 percent of LDHs reported a good or excellent relationship with at least one MCO. There should be a structured way to share information about the various arrangements among all the participants. This might include an annual conference, written descriptions of effective collaborations and annual recognition awards.

3. **As a source of current health and public health information, the SDOH should provide technical assistance to MCOs and LDHs in data acquisition, analysis, reporting and use.**

   SDOH should build on existing approaches to expanding access to data for both quality assurance and community health planning purposes[9]. SDOH should continue to explore the capabilities of generating data in different formats that meet local needs (e.g., producing data by county and providing public health related data such as immunizations, lead screening, etc.). Either as part of existing SDOH workgroups or as a separate workgroup, SDOH should provide a forum for MCO, LDH and LDSS representatives to review existing data sources (Quality Assurance Review Reports, consumer surveys, special studies, public health reports/data) and identify access, training and new data needs.

[9] Since 1998, the SDOH has used grants from the CDC (Assessment Initiative) and the Robert Wood Johnson Foundation (Turning Point Initiative) to strengthen community health assessment capacity and practice. An outgrowth of the Assessment Initiative is the Community Health Clearinghouse: a user-friendly tool to provide community health practitioners with access to local, state and national public health data sets, resources and tools to assist the practitioners conduct effective community health assessment processes. Work has begun to identify QARR indicators that are useful for public health planning, surveillance and assessment purposes, and can be placed on the Community Health Clearinghouse.

APPENDIX A

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APPENDIX B

LITERATURE REVIEW

Literature Review

A search of the literature was conducted on LDH/MCO collaboration, using the database of the National Library of Medicine and accessed through its "Pub Med" search engine. While there were numerous articles found that examined the impact of managed care on public health, there were only about a dozen that described models of collaboration between LDHs and MCOs. In this review, the articles that present collaborative frameworks are presented first, followed by articles that make more specific points about aspects of the LDH/MCO collaborative process.

Leviss and Hurtig (1998), with experience in New York City, present different models of LDH/MCO interaction as well as describe a framework for analyzing the stages of the collaborative process. Models of interaction are based on the roles the LDH plays with respect to the MCO. These include the LDH as a: 1) managed care organization, 2) service provider, 3) convener/facilitator, 4) advocate, 5) quality monitor, 6) educator, and 7) provider of strengthened core public health services. The authors list 10 stages in the collaboration process: 1) assess the internal and external environment, 2) redefine the mission, 3) identify appropriate models for interaction with MCOs, 4) establish collaborative relationships with key players, 5) develop structures to support models of collaborative relationships, 6) develop new policies and procedures, 7) develop marketing materials to reflect chosen methods, 8) develop the necessary systems infrastructure, 9) stage and implement models for interaction, 10) evaluate collaborations.

Halverson et al. (1997) present a typology of models for LDH/MCO interaction based on "three broad dimensions" 1) the strategic attributes – the motivations, goals and objectives of the public health and managed care organizations; 2) the functional attributes i.e. the range of activities pursued by the public health and managed care organizations in their collaboration, and 3) the structural attributes – the mechanisms of interaction in the public health/managed care relationship. Strategic models are of 3 types: opportunistic, shared services, and stakeholder, with the last being the model with

the highest degree of collaboration. Functional models of interaction describe the content of the relationship between public health agencies and managed care in terms of 6 areas: health planning and policy development, outreach and education, data collection, community health assessment, provision of enabling services, provision of clinical services, and case management. Structural models of interaction are described within a continuum of integration with the single ownership model (the LDH and the MCO are a single organization) representing the highest level of integration.

In an approach that might fall under Halverson's et al. (1997) "strategic dimension of collaboration", McLaughlin (1998) examines the divergent interests and priorities of 3 groups of actors: managed care plans, public health officials, and legislators. While each group is interested in cost-containment, quality, and access to care, he believes the groups prioritize these goals in different ways. In the case of managed care, the priority ranking is (first to last) cost, quality, and access; for public health the ranking is access, quality, and cost; and for legislators the ranking is cost, access, and quality. In addition, the author points out that the time frames are different for each of these groups. MCOs that are for-profit typically have a 3-12 month time frame; MCOs that are not-for-profit have a 1 to 2 year outlook. Legislators have a 2 to 4 year time horizon. Public health officials focus on a time period that can range from 1 to 20 years. These differences in priorities and time frames can create obstacles to strategic cooperation between managed care plans and public health departments.

Rosnick (1998) examines potential MCO/LDH collaboration from the managed care perspective. He cites several areas of functional collaboration that are similar to those presented in other articles read for this literature review. He also points out several areas in which the roles and responsibilities of MCOs and LDHs diverge. For example, LDHs are typically responsible for an entire community, not just a group of enrollees. Also, the perspective of the LDH includes social, environmental, economic issues and is, thus, considerably broader than that of the MCO. Of interest is his description of potential barriers to collaboration, including the information burden on MCOs that already exists for reporting e.g. HEDIS and regulatory agencies; the problem of confidentiality in

sharing patient information with public health departments; the problem of incompatible information systems, and the liability risk to the MCO in delegating functions to public health departments which may vary in their capability to provide services to managed care enrollees. He states: "The major benefit of partnerships between managed care and public health will not be the contractual relationship between the two, but rather the opportunity to learn from each other." (p.82). This is similar to the "stakeholder" model of collaboration mentioned by Halverson et al. (above) in which both public health and managed care organizations view each other as mutual resources in the accomplishment of their respective missions.

Scutchfield et al. (1998) describe a set public health activities around which MCOs and LDHs can and should collaborate. These activities are similar to those presented by Leviss and Hurtig. One activity suggested by Scutchfield, not noted in the other articles, is MCO collaboration with the LDH in promoting prevention-oriented social and economic policies/laws e.g. regarding tobacco control, use of bicycle helmets, control of firearms, etc. While the logic of such activities is persuasive they might be seen by some (for example, Rosnick, 1998) as going beyond the appropriate scope of services for the MCO. Another suggestion the authors make is for the MCO to participate in public health workforce development and research, for example providing field placements in health plans for public health students.

Rutherford (1998), with a somewhat narrower focus, examines the potential impact of managed care on the functions of public health departments to control communicable diseases. These functions are disease surveillance; disease investigation, outbreak control, and contact tracing; clinical preventive services; laboratory services; and health education. In addition to presenting several examples of collaboration that are similar to those described in other articles, the author raises an interesting concern about the possibility that laboratory evaluation of communicable diseases may become less effective because of the greater likelihood of managed care plans to limit the use laboratory services. The author believes that clinical preventive services should be standardized across plans in order not to give a financial advantage to those plans that

elect not to provide an adequate level of these services. These benefits can be standardized either through regulation or through the purchasing power of the state.

Mays et al. (2000/2001) conducted a national study of 60 diverse markets to identify the degree to which MCOs had developed cooperative relationships with local health departments. Most of the areas of relationship they describe are identical to those discussed in the Leviss and Hurtig article. The authors propose a model that describes the influence of plan characteristics and market structure on MCO/LDH collaboration. While the study is useful for a national-level understanding of the factors that impact on that collaboration, its applicability to New York State is somewhat limited, in light of the fact that New York State regulations require collaboration between the MCOs and LDHs. As a result, plan structure and market forces would appear to have less of an impact on collaboration.

Two articles make a point particularly well that others make in a more general way, namely that not all managed care plans are the same (and therefore, generalizations about MCO/LDH collaboration may not apply to every plan). Roper and Mays (1998) cite the example of Medicaid-only HMOs, which are typically smaller than the commercial plans and may lack sophisticated information systems or broad referral networks. The authors suggest these plans may need more assistance from the LDH in conducting basic public health activities including outreach to vulnerable populations. Apparently the authors see no competitive advantage for the Medicaid-only plans, which might be assumed to be more familiar with the special needs of Medicaid enrollees than the commercial plans.

Friedman (1998) makes a somewhat different point regarding plan differences. In her view, whether the plan is for-profit or not-for-profit and whether it is an integrated (i.e. plan provides services, collects premiums and bears risk) versus non-integrated i.e. plan transfers risk to an association of providers (IPA model) are critically important questions. She believes that for-profit plans and those that are poorly integrated are far less likely to provide adequate services to Medicaid populations.

Schauffler and Scutchfield (1998) argue that the central issue facing public health departments is the decline in patient care revenues that results from MCOs assuming care for Medicaid patients. This trend results in a reduced capacity of LDHs to cross-subsidize care for the uninsured. In addition to the loss of revenues, some departments that have placed a heavy emphasis on providing direct patient services may find it difficult in transitioning their activities back to the core public health functions of "assurance, assessment, and policy."

Sandler and Duncan (1998) provide an excellent review of a program that provides enabling services to high-risk pregnant women and children in Rochester, NY and in Monroe County NY. The authors believe that the program offers a service model that should be supported by managed care organizations as they assume the responsibility for caring for hard-to-reach populations. They note, however, that unless savings can be shown, based on well-designed evaluations, managed care organizations are unlikely to pay for the costs of these services.

Articles Reviewed

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APPENDIX C

COVER LETTER AND MAIL SURVEYS

COVER LETTER

Dear ,

This survey is part of a study being conducted by the Center for Health Workforce Studies at the School of Public Health at the University of Albany for the Office of Managed Care, NYS Department of Health. The Medicaid Managed Care Model Contract requires each managed care plan serving the Medicaid population to coordinate its public-health related activities with the local public health agency in each county in which it operates. The model contract specifies that coordination mechanisms and protocols must be negotiated and must result in agreements regarding activities related to public health. The Department of Health provided guidelines for those agreements and, to date, 27 counties have negotiated such agreements.

The purpose of this study is to describe the current system of collaboration between local health departments and managed care organizations (MCOs) that serve Medicaid populations, and to understand the factors that promote or impede collaboration. This understanding will assist the New York State Department of Health in developing policies, programs, and technical assistance that can improve the working relationships between local health departments and MCOs. The study consists of two parts: 1) a mail survey sent to the local health departments, social services departments, and managed care organizations in each of the 27 counties with collaborative agreements, and 2) a series of in-depth interviews with key staff from each of these agencies in 6-7 counties.

In order to encourage forthright and complete responses, no answers will be attributable to any organization or individual. Responses will be presented in aggregate form only.

The survey will take approximately 15 minutes to complete. Please respond by Wednesday June 20, 2001. For your convenience, we will be sending you an e-mail version of this survey. A summary of the findings will also be sent to you when the study is completed.

We appreciate your cooperation. If you have any questions please call Steve Schreiber at (518)-402-0250 or email at **sas15@health.state.ny.us**

Sincerely,

Edward Salsberg
Director, Center for Health Workforce Studies

INSTRUCTIONS

The focus of this study is the collaborative relationships with MCOs for the core services covered by the Medicaid managed care agreements. This includes the following services:

- Immunizations
- Lead Poisoning Prevention Program
- Tuberculosis
- Infant/Child Health Assessment/Early Intervention Program
- Physically Handicapped Children's Program
- Communicable Diseases
- HIV/AIDs Protocols
- Sexually Transmitted Diseases
- Maternal/Child Health, (including in-home visits for high risk pregnancies and low birth weight babies)
- Rabies.

Other home health services of a clinical nature are not a part of this study and should not be considered in any of your responses.

There are a wide range of collaborative arrangements between local health departments and MCOs. Where questions or response categories do not apply to your department please indicate by marking "NA". In addition, since the experiences of the local health departments may vary with individual MCOs, please select the answer that best describes your situation.

SURVEY OF COLLABORATION BETWEEN LOCAL HEALTH DEPARTMENTS AND MANAGED CARE ORGANIZATIONS THAT SERVE MEDICAID POPULATIONS

SURVEY OF LOCAL HEALTH DEPARTMENTS

1. What are the forms of the agreements between your health department and MCOs covering Medicaid managed care enrollees? Please indicate the number of agreements for each of the following categories.

   Appendix to the contract ☐☐

   Memorandum of understanding ☐☐

   Informal agreement ☐☐

   Total number of MCOs ☐☐

2. As a result of Medicaid managed care, has your health department increased or reduced its delivery of health care services, such as well child clinics? Check the appropriate response.

   ☐ Increased

   ☐ Decreased

   ☐ No Change

   ☐ Not Applicable

3. As a result of Medicaid managed care, does your health department now provide services that it did not previously provide? Yes ☐ No ☐ If yes, please describe.

   _____
   _____
   _____
   _____

4. Has your health department designated staff to be liaison(s) with the MCOs?

Yes ☐ No ☐ If yes, please list the title(s) of the person(s) representing the health department.

Title(s): of persons representing the health department:

_____

_____

_____

_____

5. Have any of these Medicaid agreements led to service arrangements that involve populations other than Medicaid enrollees? Yes ☐ No ☐ If yes, please describe the service arrangements and populations.

_____
_____
_____
_____

6. In the last 12 months have you met with the MCOs that serve Medicaid enrollees in your county? Yes ☐ No ☐ If yes, complete the following.

   ☐ All of the MCOs

   ☐ Some of the MCOs, specify <u>number</u> of MCOs ☐☐

   Estimated number of meetings and/or conference calls that have been held in the past 12 months. ☐☐

7. With respect to the core services[10], has your health department developed policies and procedures that govern the relationship between your department and at least one MCO? Yes ☐ No ☐ If yes, check all that apply.

Services	Policies and procedures developed?	Has training been conducted for health department staff in these policies and procedures?
Communicable disease reporting requirements	☐	☐
MCO enrollee identification	☐	☐
Patient referrals	☐	☐
Medical protocols	☐	☐

[10] Immunizations, Lead Poisoning Prevention; Tuberculosis; Infant/Child Health Assessment/Early Intervention Program; Physically Handicapped Children's Program; Communicable Diseases; HIV/AIDS; Sexually Transmitted Diseases; Maternal/Child Health; and Rabies

Billing	☐	☐
Documentation of patient's prior services	☐	☐
Fee schedule	☐	☐
Other (please list below:)	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

8. Does your health department distribute information to MCO network providers and/or their enrollees on 1) current public health threats or 2) long term public health problems?

   Information on current public health threats:

   Yes ☐ No ☐ If yes, please provide a few samples of materials.

   Information on long term public health problems:

   Yes ☐ No ☐ If yes, please provide a few samples of materials.

9. Has your health department developed a systems infrastructure to work with the MCOs?

   Yes ☐ No ☐ (if no, go to question #10)

   If yes, check all that apply.

Billing systems for generating indiv or third-party bills	☐
Information systems for communicating individual-level data to the MCO	☐
Information systems for collecting data on enrollees insurance status	☐
Other (please list below:)	☐
_____	☐
_____	☐
_____	☐

10. If no to question #9, check all that apply.

	Not a high priority	Lack sufficient technical resources
Billing systems for generating individual or third-party bills	☐	☐
Information systems for communicating individual-level data to the MCO	☐	☐
Information systems for collecting data on enrollees insurance status	☐	☐

11. Have the MCOs participated in community health education outreach campaigns sponsored by your health department?

Yes ☐ No ☐ If yes, please describe.

_____
_____
_____
_____

12. Have the MCOs participated in community health assessment and planning activities sponsored by your health department?

Yes ☐ No ☐ If yes, what roles have MCO staff played?

_____
_____
_____

_____

13. Has the your health department used data provided or compiled by the New York State Department of Health in any collaborative efforts with MCOs?

Yes ☐ No ☐ If yes, check all that apply.

☐ QARR

☐ MEDS

☐ Public health data – for example, the Community Health Data Set

☐ Other (please specify)

_____
_____
_____

14. Has your health department worked with the MCOs to improve plan performance on any public health measures? Yes ☐ No ☐ If yes, check all that apply.

☐ Initial access to prenatal care

☐ Well child visits

☐ Lead screenings

☐ Immunizations

☐ Tobacco use screening rates

☐ Breast cancer screening rates

☐ Other (specify): _____

15. In general, how effective are the procedures for referrals by MCOs and for reimbursement for TB and immunization services?

	Very Ineffective	Somewhat Ineffective	Somewhat Effective	Very Effective
Immunizations				
Referrals	☐	☐	☐	☐
Reimbursements	☐	☐	☐	☐
TB				
Referrals	☐	☐	☐	☐
Reimbursements	☐	☐	☐	☐

16. Do network providers regularly report required information to local health departments? Yes ☐ No ☐ If yes, check all that apply.

	All Providers	Most Providers	Few Providers	None
Immunizations	☐	☐	☐	☐
Lead	☐	☐	☐	☐
STDs	☐	☐	☐	☐
TB	☐	☐	☐	☐
Other (please list below:)				
_____ _____	☐	☐	☐	☐
_____ _____	☐	☐	☐	☐

17. How frequently do the network providers in MCOs that serve Medicaid managed care enrollees engage in the activities listed below?

	Never	Rarely	Occasionally	Frequently	Always	Unknown
Participate in local and state registries	☐	☐	☐	☐	☐	☐
Cooperate with the local health officer conducting STD investigations	☐	☐	☐	☐	☐	☐
Have providers communicate with your health department concerning medical management of elevated blood levels for lead.	☐	☐	☐	☐	☐	☐
Consult with your health department concerning lead abatement in the	☐	☐	☐	☐	☐	☐

enrollee's environment

18. Have MCOs contracted with your health department to purchase services for Medicaid managed care enrollees? Yes ☐ No ☐ If yes, for each service area, please indicate the number of MCOs with which you have contracts.

	Number of MCOs with which contracts exist.	None (no contract exists for this area)
Dental care	☐	☐
Home Health (CHHA)	☐	☐
Patient Enabling Services[1]	☐	☐
Family Planning	☐	☐
Injury Prevention	☐	☐
Prenatal	☐	☐
Well Child	☐	☐
Domestic Violence Prevention	☐	☐
Other (please list below:)	☐	☐
_____ _____	☐	☐
_____ _____	☐	☐
_____ _____	☐	☐

_____

19. Please attach a copy of the reimbursement rates provided by the MCOs for all services rendered by your health department to Medicaid managed care enrollees.

20. How would you describe the overall relationship between your health department and the MCOs that serve Medicaid Managed Care enrollees? Please list the number of MCOs in each category

Excellent, cooperative relationship	☐☐
Good relationship	☐☐
Poor relationship	☐☐
No relationship	☐☐
Total number of MCOs	☐☐

21. How would you rate the degree of collaboration between your health department and MCOs in the following areas?

	Extensive		Moderate		None
	5	4	3	2	1
☐ Immunization	☐	☐	☐	☐	☐
☐ Lead Program	☐	☐	☐	☐	☐
☐ T.B.	☐	☐	☐	☐	☐
☐ Infant/Child Assessment/Early Intervention Program	☐	☐	☐	☐	☐
☐ Physically Handicapped Children's Program	☐	☐	☐	☐	☐
☐ Communicable Diseases	☐	☐	☐	☐	☐
☐ Sexually Transmitted Diseases	☐	☐	☐	☐	☐
☐ HIV/AIDS	☐	☐	☐	☐	☐
☐ Maternal/Child Health	☐	☐	☐	☐	☐

☐ Rabies	☐	☐	☐	☐	☐
☐ Other (please list below)	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

22. What are the most important barriers to collaboration between your health department and MCOs?

_____
_____
_____
_____

23. What are the most important factors that contribute to the success or failure of the collaboration between your health department and MCOs?

_____
_____
_____
_____

24. For the principal parties involved in the process of collaboration between your health department and the MCOs, what county-level changes could be made to improve the collaboration process?

_____
_____
_____
_____

25. What could the New York State Department of Health do to further develop collaboration between your health department and MCOs?

_____
_____
_____
_____

Other Comments/Suggestions: _____

_____
_____
_____
_____

Name of Person Completing the Survey:_____

Name of Health Department:_____

Title:_____

Phone Number:_____ Fax:_____ E-mail:_____

THANK YOU FOR COMPLETING THE SURVEY.

Please mail to:
Center for Health Workforce Studies
University at Albany
School of Public Health
1 University Place Room 200
Rensselaer, NY 12144-3456

SURVEY OF COLLABORATION BETWEEN LOCAL HEALTH DEPARTMENTS AND MANAGED CARE ORGANIZATIONS THAT SERVE MEDICAID POPULATIONS

SURVEY OF LOCAL SOCIAL SERVICES DEPARTMENT ACTIVITIES

INSTRUCTIONS

The focus of this study with local health departments, is the collaborative relationships that are in place for the core services covered by the Medicaid agreements. This includes the following services:

- Immunizations
- Lead Poisoning Prevention Program
- Tuberculosis
- Infant/Child Health Assessment/Early Intervention Program
- Physically Handicapped Children's Program
- Communicable Diseases
- HIV/AIDs Protocols
- Sexually Transmitted Diseases
- Maternal/Child Health, (including in-home visits for high risk pregnancies and low birth weight babies)
- Rabies.

Other home health services of a clinical nature are not a part of this study and should not be considered in any of your responses.

There are a wide range of collaborative arrangements between local health departments and MCOs. Where questions or response categories do not apply please indicate by marking "NA". In addition, since the experiences of the local health department may vary with individual managed care organizations, please select the answer that best describes the situation in your county.

1. Has the LDSS facilitated collaboration between the local health departments and MCOs?

   Yes ☐ No ☐ If yes, check all that apply.

   ☐ Arrange meetings
   ☐ Engage in problem identification and resolution

☐ Provide technical assistance
☐ Other (please specify):

2. Does your department have liaisons(s) with local health departments and MCOs to work on Medicaid managed care agreements?

Yes ☐ No ☐

Title(s): of persons representing the LDSS:

Estimated <u>number</u> of meetings and/or conference calls that have been held in the past 12 months with MCOs and local health departments on Medicaid managed care issues: __

3. Has the LDSS provided the local health department with any Medicaid managed care related data? Yes ☐ No ☐ If yes, please describe.

4. Has the LDSS involved the local health department in any LDSS-managed-care related activities?

Yes ☐ No ☐ If yes, check all that apply.

☐ Outreach
☐ Consumer education
☐ **Other(please specify):**

5. With how many MCOs does your county health department have a relationship? ___
From the perspective of the LDSS, please indicate the <u>number</u> for which collaboration, overall, is:

Satisfactory ___

Unsatisfactory ___

Unknown ___

6. Please indicate the degree of collaboration between your county health department and the MCOs in any of the following areas. Check all that apply.

	Extensive 5	4	Moderate 3	2	None 1	Unknown
Immunization	☐	☐	☐	☐	☐	☐
Lead Program	☐	☐	☐	☐	☐	☐
T.B.	☐	☐	☐	☐	☐	☐
Infant/Child Assessment/Early Intervention Program	☐	☐	☐	☐	☐	☐
Physically Handicapped Children's Program	☐	☐	☐	☐	☐	☐
Communicable Diseases	☐	☐	☐	☐	☐	☐
Sexually Transmitted Diseases	☐	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐	☐
Maternal/Child Health	☐	☐	☐	☐	☐	☐
Rabies	☐	☐	☐	☐	☐	☐
Other (please list below)	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐

7. What are the most important factors that contribute to the success or failure of the collaboration between the county health department and MCOs?

8. For the principal parties involved in the process of collaboration between the county health department and the MCOs, what county-level changes could be made to improve the collaboration process?

9. What could the New York State Department of Health do to further develop collaboration between your county health department and MCOs?

Other Comments/Suggestions:

Name of Person Completing the Survey:

Title:

Phone Number: Fax: E-mail:

Name of Social Services Department:

THANK YOU FOR COMPLETING THE SURVEY.

Please mail to:

Center for Health Workforce Studies
University at Albany
School of Public Health
1 University Place Room 200
Rensselaer, NY 12144-3456
or FAX to (518) 402-0252

If you have any questions please call:
Steven Schreiber, Ph.D. at (518) 402-0250 or
e-mail to: sas15@health.state.ny.us

SURVEY OF COLLABORATION BETWEEN LOCAL HEALTH DEPARTMENTS AND MANAGED CARE ORGANIZATIONS THAT SERVE MEDICAID POPULATIONS

SURVEY OF MANAGED CARE ORGANIZATIONS

INSTRUCTIONS

The focus of this study with local health departments, is the collaborative relationships that are in place for the core services covered by the Medicaid agreements. This includes the following services:

- Immunizations
- Lead Poisoning Prevention Program
- Tuberculosis
- Infant/Child Health Assessment/Early Intervention Program
- Physically Handicapped Children's Program
- Communicable Diseases
- HIV/AIDs Protocols
- Sexually Transmitted Diseases
- Maternal/Child Health, (including in-home visits for high risk pregnancies and low birth weight babies)
- Rabies.

Other home health services of a clinical nature are not a part of this study and should not be considered in any of your responses.

There are a wide range of collaborative arrangements between local health departments and MCOs. Where questions or response categories do not apply to your MCO please indicate by marking "NA". In addition, since the experiences of the MCOs may vary with individual health departments, please select the answer that best describes your situation.

1. With how many county health departments does your MCO have written agreements covering the Medicaid managed care enrollees?

Number of counties: ___

2. Has your MCO designated staff to be liaison(s) with the local health departments?

Yes ☐ No ☐ If yes, please list the title(s) of the person(s) representing the MCO.

Title(s): of persons representing the MCO:

3. In the last 12 months has your MCO met with the local health departments in any of the counties in which you operate? Yes ☐ No ☐ If yes, check the correct answer.

☐ All of the county health departments
☐ Some of the county health departments, specify number: ___

Estimated number of meetings and/or conference calls that have been held with local health departments in the past 12 months: ___

4. Have the Medicaid managed care agreements with the local health departments led to service arrangements that involve populations other than Medicaid enrollees?
Yes ☐ No ☐ If yes, please describe the service arrangements and populations.

5. With respect to the core services[11], does your MCO have specific policies and procedures that govern the relationship between your MCO and at least one health department? Yes ☐ No ☐ If yes, check all that apply.

Services	Policies and procedures developed?	Have MCO staff been trained in these policies and procedures?
Communicable disease reporting requirements	☐	☐

[11] Immunizations, Lead Poisoning Prevention; Tuberculosis; Infant/Child Health Assessment/Early Intervention Program; Physically Handicapped Children's Program; Communicable Diseases; HIV/AIDS; Sexually Transmitted Diseases; Maternal/Child Health; and Rabies

Enrollee identification	☐	☐
Patient referrals	☐	☐
Medical protocols	☐	☐
Billing	☐	☐
Documentation of patient's prior services	☐	☐
Fee schedule	☐	☐
Other (please list below:)	☐	☐
	☐	☐
	☐	☐

6. Has your MCO participated in community health education outreach campaigns sponsored by the local health department?

Yes ☐ No ☐ If yes, please describe.

7. Has your MCO participated in community health assessment and planning activities sponsored by the local health department?

Yes ☐ No ☐ If yes, what roles have MCO staff played?

8. Has your MCO used data produced or compiled by the New York State Department of Health in any collaborative efforts with local health departments?

Yes ☐ No ☐ If yes, check all that apply.

☐ QARR
☐ MEDS
☐ Public health data – for example, the Community Health Data Set
☐ Other (please specify)

9. Has your MCO worked with the local health departments to improve plan performance on any public health measures? Yes ☐ No ☐ If yes, check all that apply.

☐ Initial access to prenatal care
☐ Well child visits
☐ Lead screenings
☐ Immunizations
☐ Tobacco use screening rates
☐ Breast cancer screening rates
☐ Other (specify):

10. In general, how effective have your procedures been for referrals and for reimbursement for TB and immunization services?

	Very Ineffective	Somewhat Ineffective	Somewhat Effective	Somewhat Effective	Very
Immunizations					
Referrals	☐	☐	☐	☐	
Reimbursements	☐	☐	☐	☐	
TB					
Referrals	☐	☐	☐	☐	
Reimbursements	☐	☐	☐	☐	

11. Does your MCO inform and encourage providers to report required information to the local health department in areas such as immunizations, lead poisoning control, STDs, and TB? Yes ☐ No ☐ If yes, check all that apply.

☐ Letter
☐ Phone Call
☐ Provider Manual
☐ Other (please list below)

_____
_____

12. How would you describe the overall relationship between your MCO and the local health departments in counties where you serve Medicaid Managed Care enrollees? Please list the number of health departments in each category

Excellent collaborative relationship ___

Good relationship ___

Poor relationship ___

No relationship ___

Total number of health departments ___

13. Please indicate the degree of collaboration between your MCO and the local health department in the following program areas.

Check all that apply.

	Extensive		Moderate		None
	5	4	3	2	1
☐ Immunization	☐	☐	☐	☐	☐
☐ Lead Program	☐	☐	☐	☐	☐
☐ T.B.	☐	☐	☐	☐	☐
☐ Infant/Child Assessment/Early Intervention Program	☐	☐	☐	☐	☐
☐ Physically Handicapped Children's Program	☐	☐	☐	☐	☐
☐ Communicable Diseases	☐	☐	☐	☐	☐
☐ Sexually Transmitted Diseases	☐	☐	☐	☐	☐
☐ HIV/AIDS	☐	☐	☐	☐	☐
☐ Maternal/Child Health	☐	☐	☐	☐	☐
☐ Rabies	☐	☐	☐	☐	☐
☐ Other (please list below)	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

14. What are the most important barriers to collaboration between your MCO and the local health departments?

15. What are the most important factors that contribute to the success of the collaboration between your MCO and the local health departments?

16. For the principal parties involved in the process of collaboration between your MCO and the local health departments, what county-level changes could be made to improve the collaboration process?

17. What could the New York State Department of Health do to further develop collaboration between your MCO and the local health departments?

Other Comments/Suggestions:

Name of Person Completing the Survey:

Title:

Phone Number: Fax: E-mail:

Name of Managed Care Organization:

THANK YOU FOR COMPLETING THE SURVEY.

Please mail to:

Center for Health Workforce Studies
University at Albany
School of Public Health
1 University Place Room 200
Rensselaer, NY 12144-3456

or FAX to (518) 402-0252

If you have any questions please call:

Steven Schreiber, Ph.D. at (518) 402-0250 or
e-mail to: sas15@health.state.ny.us

APPENDIX D

ORGANIZATIONS THAT COMPLETED THE MAIL SURVEY

County Health Departments

1. Albany
2. Broome
3. Chautauqua
4. Cortland
5. Dutchess
6. Erie
7. Greene
8. Herkimer
9. Livingston
10. Madison
11. Monroe
12. Nassau
13. New York City
14. Niagara
15. Onondaga
16. Ontario
17. Orange
18. Oswego
19. Rensselaer
20. Rockland
21. Saratoga
22. Schenectady
23. Suffolk
24. Westchester
25. Wayne

County Social Services Departments

1. Albany
2. Broome
3. Chautauqua
4. Columbia
5. Cortland
6. Dutchess
7. Erie
8. Greene
9. Herkimer
10. Livingston
11. Madison
12. Monroe
13. Nassau
14. New York City
15. Niagara
16. Oneida
17. Onondaga
18. Ontario
19. Orange
20. Oswego
21. Rensselaer
22. Schenectady
23. Suffolk
24. Westchester
25. Wayne

Managed Care Organizations

1. Americhoice
2. Health source/Hudson
3. Buffalo Com. Health
4. Total care
5. Suffolk health plan

6. BC/BS Buffalo(WNY)
7. Metro Plus
8. Independent Health
9. Fidelis Care
10. ABC Health Plan
11. BC/BS Rochester
12. Health Plus
13. CDPHP
14. HIP Health Plan
15. Community Choice Health Plan
16. Care Plus Health Plan
17. Neighborhood Health Providers

APPENDIX E

INTERVIEW PARTICIPANTS

Persons Interviewed

New York City

New York City Department of Health
Division of Health Care Access
James Capoziello, Deputy Commissioner

Fidelis
Mark Lane, President and CEO
Mary Ellen Connington, Vice President
David Thomas, Vice President for Strategic Planning and Contracting

Neighborhood Health Providers
Judith Cashman, RN, Vice President, Clinical and Preventive Services

Health Insurance Plan of New York
Francis Olsen, DDS, MPA
Senior Vice President, Product Coordination and Oversight

Health Plus
Tom Early, Executive Director
Clifford Marbut, MD, Medical Director

Metro Plus
Barbara Radin, Executive Director

Westchester County

Westchester County Department of Health
Renee O'Rourke, Assistant Commissioner, Planning and Evaluation

Westchester County Department of Social Services
Dennis Packard, Assistant Commissioner
Barbara Katz, Managed Care Coordinator

Health Source Hudson Health Plan (Westchester PHSP)
Janet Sullivan, MD, Medical Director
Maxcy Smith, MD, Consultant
Margaret Leonard, Vice President, Clinical Services

Albany County

Albany County Department of Health
Margaret DiManno, Assistant Commissioner
Capital District Physicians Health Plan
Mary Ellen Hanrahan, Manager, Government Programs

Albany County Department of Social Services
Ross Prinzo, Commissioner
Donna McCoy, Manager, Medicaid Managed Care

Onondaga County

Onondaga County Department of Social Services
David Sutkowy, Commissioner

Onondaga County Department of Health
Amanda Nestor, Public Health Administrator
Florence Schweitzer, Program Coordinator
Susan Serrano, Nursing Supervisor

Total Care
Angela Zeppetello, Vice President, Chief Operating Officer

Monroe County

Monroe County Department of Health
Andrew Doniger, MD Director

Monroe County Department of Social Services
Linda Russell, Medicaid Managed Care Coordinator

Blue Cross Blue Shield of the Rochester Area
Mary Lane, Director , Network Partnerships and Government Programs

Erie County
Erie County Department of Social Services
Jack O'Connor, Director, Managed Care

Independent Health
Shirley Fohl, Product Administrator, Medicaid Managed Care

Blue Cross Blue Shield of WNY (Community Blue)
Michael Ezzie, Director of Medicaid Managed Care

Buffalo Community Health

Valerie Rosenhoch, Executive Director

Chautauqua County

Chautauqua County Department of Health
Samuel Thorndike, Ph.D., Director of Public Health
Patricia Allenson, Director of Patient Services
Jeffery Beach, Deputy Director, of Finance

Chautauqua County Department of Social Services.

APPENDIX F

OPEN-ENDED RESPONSES TO MAIL SURVEY

Factors promoting collaboration

- General organizational qualities - leadership, good communications, clear roles and responsibilities, adequate resources, timely information, streamlined paper work, shared or common goals, flexibility, and consistent representation from interdepartmental liaisons.

- Support from the LDSSs.

- Education and support from SDOH on what is required of the MCOs in the public health agreements.

- MCO interest in collaboration – in one county one MCO was seen as leading the collaborative effort (in contrast to the other plan which was not viewed as a team player).

- Integrated organizational structure - In one county, a unit of the LDH managed the Medicaid managed care contracts with the MCOs, had direct linkages to other units of the LDH and reported to the LDH commissioner.

- Demonstration of positive public health outcomes – Examples included a decrease in low birth weight babies, an increase of early entry into prenatal care, and in another county it was improvement in HEDIS (Health Plan Employer Data and Information Set) measures.

Factors impeding collaboration

- Absence of the factors that led to collaboration.

- Some LDHs did not think that MCOs saw the need for providing basic health services such tuberculosis care, immunizations etc. since the MCOs thought that these activities were LDH responsibilities.

- Variations in what was expected of MCOs. One MCO mentioned that each county had its own unique program requirements and ideas as to what constitutes an effective program. Thus, it was difficult for an MCO serving multiple counties to develop and maintain programs that satisfied the requirements of the individual counties.

- Conflict of roles - One MCO expressed the view that the role of LDH as both the provider of service and regulatory agency was a conflict of interest. (Note: Since LDHs have no formal regulatory role, the meaning of this comment is not clear).

- Negative view of managed care - One MCO cited "managed care bashing" on the part of some LDH employees as a factor that impeded collaboration.

- Lack of awareness of how managed care works- One MCO expressed the view that there was no understanding on the part of some LDH staff of what managed care organizations did and how the referral and authorization processes worked.

- An MCO, with a corporate office located several hundred miles away, was thought to be less dedicated to work with the LDH.

Suggested county-level changes that could improve the collaboration process

- Need for a closer working relationship between the LDH and the LDSS.

- Articulate and enforce the requirement that there be operational contracts with the LDH for services rendered.

- LDHs should encourage new providers in the LDH system to apply for credentialing in their plan.

Suggestions for the SDOH to improve LDH/MCO Collaboration

- Clarify role of LDHs with MCOs, establish guidelines, and promote county health department services to the MCOs.

- Provide feedback on public health priority issues in order to develop proposals and allocate resources.

- Share data, study findings, and best practices regarding disease management and treatment protocols on a variety of health care topics as well as health indicators.

- Introduce the LDHs to the MCOs to foster a good future relationship.

- Educate MCOs on insurance coverage so they do not withhold payment to LDHs for some programs.

- Standardize public health addendum language in managed care contracts.

- Encourage the LDH to sign and implement the public health agreements.

- Provide assistance to LDHs using staff with managed care expertise.

- Use teleconferencing as a means to reach various parties with the same information and to avoid confusion about the responsibilities of the parties.

- Implement public health protocols that are the same for all counties and all MCOs, instead of allowing for local variation.

- Continue to guide rather than force requirements or mandates.

- Allow flexibility for local solutions.

- Find out why there is little or no communication between parties (is it due to the lack of a satisfactory working relationship between the LDH and MCOs or is it because there has been no patient-related need to communicate?)