CASE STUDIES IN PUBLIC HEALTH AND MANAGED CARE COLLABORATIONS

An Evaluation of Emerging Relationships Through Memoranda of Understanding Between Managed Care Organizations and Public Health Agencies:

Implications for Population-Based Communicable Disease Prevention and Control Programs and Public Health Policy

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D. Richard Mauery, M.P.H., Research Scientist
Sara Rosenbaum, J.D., Director, Center for Health Policy Research
Sabra F. Woolley, Ph.D., Research Scientist
Elizabeth Wehr, J.D., Research Scientist
Shoshanna Sofaer, Dr.P.H., Professor, Baruch College, New York City

The Center for Health Policy Research
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Table of Contents

Executive Summary 3

Introduction 5

I. Background and Overview 8

A. Legal/Jurisdictional Differences 9

B. Financial Considerations 10

C. Traditional World-View Perspectives 12

II. Study Design, Questions, and Research Methodology 12

III. Analysis of Memoranda of Understanding 16

A. Overview of Documents 16

B. Findings from MOU Analysis 18

1. MOUs as Classic Provider Agreements 24

2. MOUs as Applicable to All Books of Business 24

3. MOUs as Reflective of Managed Care, Not Public Health, Imperatives 25

4. Similarities and Differences Among MOUs 25

IV. Results from Site Visits 31

A. Overview of Study Sites 31

B. Key Findings from Site Visits 34

1. From Expectation to Realization: The Emergence of Public Health and Managed Care Relationships 34

2. The MOU as Catalyst 39

3. The MOU Development Process 39

4. The MOU Negotiation Process 41

5. Potential Effects of MOUs on Specific Aspects of Communicable Disease Programs 43

V. Conclusions 50

A. The MOU Process is an Important One That Should be Promoted, Closely Monitored, and Measured 50

B. Despite Its Importance, the MOU Process Cannot Be Expected to Resolve Major Policy Matters that Transcend Specific Provider Agreements 53

VI. Recommendations 55

EXECUTIVE SUMMARY

Enrollment of Medicaid-eligible persons in managed care delivery systems has grown rapidly in the U.S., up from 9.5% of Medicaid beneficiaries in 1991 to 47.8% in 1997.[1] States have turned to managed care to achieve the dual goals of enrolling Medicaid beneficiaries into comprehensive health care systems, and achieving cost-savings. A large body of anecdotal evidence suggests that the growth of Medicaid managed care has affected the range of personal health services they offer to individuals and the manner in which they carry out their community-wide public health responsibilities. Collaboration between public health agencies and managed care organizations thus has taken on great urgency, as the new health system emerges.

This study examines the use of a specific tool intended to facilitate and formalize such collaborations: memoranda of understanding (MOUs) and other written agreements between public health agencies and managed care organizations. Within the overall MOU framework, the study focuses on their use in advancing managed care/public health relationships around communicable disease: sexually transmitted diseases, vaccine-preventable diseases, HIV/AIDS, and tuberculosis. The research team employed two approaches in carrying out this analysis: 1) site visits around the country to conduct interviews with people involved in, and knowledgeable about, these collaborations; and 2) a legal analysis of the study sites' master Medicaid contracts and MOUs developed by local agencies.

The study findings indicate that the initial use of these local agreements represented an important first step as a catalyst for collaboration, serving to bring the domains of public health and managed care together to discuss their mutual and discrete responsibilities. These "first wave" agreements, however, contain a critical limitation: they resemble standard service agreements between managed care organizations and network providers and thus address the role of public health agencies in delivering contract services to managed care enrollees. By and large, the current generation of agreements does not bring managed care organizations into the wider realm of population-based health activities, such as disease surveillance, data collection and reporting, community-wide public health education, and disease prevention efforts that would ultimately benefit managed care enrollees. The limits of the MOUs reflect the context (i.e., a

[1] HCFA, *National Summary of Medicaid Managed Care Programs and Enrollment: June 30, 1997 Managed Care Trends.* Available at: http://www.hcfa.gov/medicaid/trends97.htm. Accessed May 25, 1998.

provider agreement), the expectations on the part of Medicaid agencies and state public health agencies, and the large number of unresolved policy issues arising from the integration of managed care structure and operations into public health practice.

The study **recommends** that:

1) the CDC actively encourage the expanded use of MOUs as a mechanism for initiating collaboration between managed care and public health;
2) there is a significant opportunity for the CDC to assume a leadership role in the provision of comprehensive technical assistance to state Medicaid agencies and state and local health departments in promoting MOU development and broader public health policy and practice in a managed care context;
3) expanded attention is needed to more issues that are essential to public health/managed care integration but that are not reflected in MOUs; and,
4) given the social stigma of diseases such as STDs and HIV, state health and Medicaid agencies need to consider better ways to accommodate the need for public provision of these services and their financing, such as continued and expanded direct funding to local public health agencies specifically for these purposes, as well as the development of new billing mechanisms that are responsive to both public health and MCO reporting requirements.

INTRODUCTION

In recent years, states increasingly have turned to mandatory managed care arrangements for Medicaid beneficiaries to find more cost-effective and efficient means of delivering health services to this population. Managed care systems in turn are having a significant impact on both the organization and delivery of health care, as well as the manner in which population based public health activities are conceived and carried out.[2] Public health agencies throughout the nation report that managed care has affected the range of personal health services they offer, the range of activities in which they engage, and the manner in which they carry out their public health responsibilities.[3]

While the managed care movement generally has affected public health agencies, it is probably fair to say that Medicaid managed care has had a particularly great impact for several reasons: the extent to which public health agencies are engaged in overseeing and furnishing health care for low income populations; their involvement in monitoring community and public health risks, which disproportionately confront poor Americans; and the fact that many public health agencies rely extensively on Medicaid revenues to directly support their personal health care services and activities, and to act as an indirect cross-subsidy for both personal health care for the uninsured and population-based activities. Thus, one of the most important public policy issues that merits consideration in an age of managed care concerns the extent to which the evolution of the American health system will change the manner in which public health oversight, health care assurance, and monitoring functions are conducted.

This study, conducted for the Centers for Disease Control and Prevention under a cooperative agreement focusing on managed care and public health, examines the advent and growth of a specific tool for establishing and maintaining a relationship between managed care organizations (MCOs) and local public health agencies: memoranda of understanding (MOUs) which are entered either on a mandatory or voluntary basis, as an incident to the contractual

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[2] See, e.g., Harris JR, Caldwell B, Cahill K. Measuring the public's health in an era of accountability: lessons from HEDIS. *Am J Prev Med.* 1998;14(3S):9-14; Remarks of Dr. Mark Smith *Am J Prev Med.* 1998;14(3S):4-7; Rutherford GW. Public health, communicable diseases, and managed care: will managed care improve or weaken communicable disease control. *Am J Prev Med.* 1998;14(3S):53-60; Remarks of Emily Friedman, Prevention, public health, and managed care: obstacles and opportunities. *Am J Prev Med.*1998;14(3S):102-106.

relationship that exists between a state Medicaid purchaser and the MCO. This study, which is part of a series of studies and activities designed to assess and shape the degree to which Medicaid managed care contracts address major issues in public health policy and practice, examines the origins of the managed care MOU process, the content and structure of the MOUs that have been created to date, and the experiences of local public health agencies in developing and implementing the MOUs. We conclude that the MOU process can play an extremely useful role in educating public health agencies about managed care and sensitizing MCOs to issues affecting public health agencies.

In addition, we find that MOUs resemble a managed care provider network agreement and thus are a useful means for integrating certain activities of local public health agencies into community managed care operations. MOUs and similar agreements between MCOs and public health agencies represent important tools implementing service and network related aspects of the master agreement between the state and the MCO. Depending on how they are drafted, MOUs may attain legally enforceable status and establish an interaction baseline between the health agency and the MCO. As supplier agreements, MOUs can be used to define the scope of duties, roles and responsibilities, and financial arrangements between MCOs and public health agencies with respect to Medicaid enrollees; furthermore, while Medicaid purchasers tend to be the buyers most interested in the development of an MCO/public health relationship, there is no reason why an MOU, once established, cannot be applied by the MCO and the public health agency to all of the MCO's books of business, whether commercial or public.

At the same time, however, our findings lead us to conclude that MOUs can be expected to have only a limited effect at best on the resolution of certain fundamental public health policy issues that arise in the wake of managed care, including the duties of MCOs to ensure access to care that is determined medically necessary for the protection of the public's health, access by state and local public health agencies to data that are necessary for community-wide disease surveillance and management, participation by managed care organizations in larger community efforts to control public health threats, and adherence to quality improvement standards advocated by public health agencies as a means of community-wide public health protection.

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[3] See, e.g., Testimony of Dr. Magda Peck, Director, CityMatCH, before the Institute of Medicine hearing on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers (Washington D.C., May 7-8,

These issues transcend any individual relationship that may (or may not) develop between a particular MCO and a public health agency and remain central matters for resolution in both the contracts between purchasers and MCOs, as well as in state law. Nonetheless, MOUs offer a means of laying the groundwork for a relationship between managed care and public health and are tools which we believe should be actively pursued.

This study begins with a Background and Overview that explores key aspects of the relationship between managed care and public health. The study premises and methods employed are presented in the next section. The third section presents the results of our analysis of the MOUs and our field studies. We then consider the implications of our research and make a series of recommendations.

1998).

I. Background and Overview

In recent years, relationships between public health agencies and managed care organizations have been the subject of much debate,[4] yet the complexity of the issues is rarely well understood or described at the level of detail it deserves. At first glance, public health and managed care share a complementary perspective: both appear to rest on the premise that preventive health and medical approaches can improve individual health and achieve cost savings. Moreover, both public health and managed care theorists tend to focus on the group rather than individuals, advocating collective thinking and uniform practice over the medical care needs of any single individual.[5] Both managed care and public health thus tend to emphasize principles of population-wide intervention and "macro-allocation," rather than individualized coverage decision-making and "micro-allocation," the hallmark of traditional insurance.

However, these broad assertions of common interest often obscure fundamental differences between managed care and public health. These structural issues are shaped by legal/jurisdictional, financial, and traditional world-view considerations.

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[4] ***Selected Literature:*** Halverson PK, Kaluzny AD, McLaughlin CP. *Managed Care and Public Health*, Aspen Publishers, Gaithersburg, MD, 1998. Halverson PK, Mays GP, Kaluzny AD, Richards TB. Not-so-strange bedfellows: models of interaction between managed care plans and public health agencies. *The Milbank Quarterly* 1997;75(1):113-138. Halverson PK, Kaluzny AD, Miller, CA. The determinants of interaction between managed care plans and public health agencies: implications for quality, accessibility, and efficiency in health care delivery. Washington, D.C.: Association for Health Services Research. (Abstract). 1996. Grogan CM. The Medicaid managed care policy consensus for welfare recipients: a reflection of traditional welfare concerns. *J Health Polit Policy Law.* 1997;22(3):815-838. Lipson, DJ. Medicaid managed care and community providers: new partnerships. *Health Affairs.* 1997;16(4):91-107. _____, Medicaid managed care partnerships. *J Kentucky Med Assn.* 1997:95(3):96-97. Schauffler HH, Wolin J. Community health clinics under managed competition: navigating uncharted waters. *J Health Polit Policy Law.* 1996:21(3):461-488. Gold MM, Sparer M, Chu K. Medicaid managed care: lessons from five states. *Health Affairs.* 1996:15(3):153-166. _____ , *Assessing the New Federalism: State Reports on Health Policy for Low-Income People in [Massachusetts, Michigan, Minnesota, New York, Texas, Washington*]. The Urban Institute. 1997. Lasker RD, and the Committee on Medicine and Public Health. *Medicine and Public Health: The Power of Collaboration*. New York Academy of Medicine, New York. 1997. Gold MB, Foot B, Lillie-Blanton M. *Managed Care and Low Income Populations: A Case Study of Texas*. Kaiser/Commonwealth Low-Income Coverage and Access Project. 1997. AHCPR. *Assessing Roles, Responsibilities, and Activities in a Managed Care Environment: A Workbook for Local Health Officials*. Pub. No. 96-0057, July 1996.

Selected Conferences: "Local Health Departments in a Managed Care Environment: Challenges and Opportunities." St. Louis, MO. 1996. Agency for Health Care Policy and Research. "Integrated Delivery Systems in Managed Care: Challenges to State Oversight. A Workshop for Senior State and Local Health Officials." Boston, MA. 1997. Agency for Health Care Policy and Research. "Prevention in Managed Care: Joining Forces for Value and Quality." Atlanta, GA 1997. U.S. Centers for Disease Control and Prevention.

[5] For a classic example of collective managed care theory see: Eddy D. Rationing resources while improving quality: how to get more for less. *JAMA* 1994;272:817-824.

A. Legal/Jurisdictional Differences

A public health agency's jurisdiction extends to the entire community which the agency is authorized to serve. Public health agencies have a social compact with their communities as well as a legal duty to serve the community at large; however, no individual within the community has a legally enforceable entitlement to population-based public health services. Every member of the community, insured or not, "belongs" to public health, and public health agencies attempt to maximize their resources on the community's behalf. Population-based communicable disease control and surveillance must be accomplished without regard to a particular individual's eligibility for Medicaid or any other form of insurance.

MCOs, on the other hand, possess very different duties. On the one hand, they owe a fiduciary duty to their members and their sponsors to avoid waste, maximize resources and invest the funds (i.e., the premiums) they receive to the greatest possible advantage. On the other hand, all MCOs are insurers as well as health care providers. As a result, their members have a legally enforceable right to coverage for a defined set of benefits; this entitlement obligates MCOs to perform not only collectively but on a highly individualized basis, as well.

The fact that MCOs have legally entitled members creates a further distinction with public health. Because MCOs have a collective fiduciary duty to all members, they also are obligated to use their resources to serve only their members. Put another way, MCOs do not have a social compact with their members: they have a legally enforceable obligation to serve only the insured individuals who purchase their services. The primary responsibility of MCOs is to furnish contracted personal health services to enrollees in exchange for premium payments. When insurance coverage ceases, so do virtually all duties of MCOs to the enrollees. This is a particular problem for Medicaid enrollees, because the duration of coverage tends to be quite short, averaging less than one year.[6]

To be sure, at some point the obligation to serve members properly may require that MCOs engage in services and activities that may also have the effect of benefiting non-members. Moreover, as with any private enterprise, MCOs can be thought of as having a social obligation toward the communities they serve, and many managed care enterprises are actively involved in

numerous community-wide programs. Furthermore, as regulated businesses, MCOs may have general legal duties under state or federal law, such as the obligation to comply with state insurance laws, business laws, or federal labor and tax laws. Nonetheless, the duty of an MCO is defined by those members who have a legal entitlement to coverage and care, while the duty of public health agencies is defined by their community jurisdiction.

B. Financial Considerations

MCOs operate on a financial risk basis – they sign contracts that require them to provide defined contractual services to enrollees for a fixed fee (typically paid monthly). Thus, for example, an MCO that contracts to furnish certain services cannot arbitrarily discontinue coverage for certain services (e.g., childhood immunizations or drugs) during the term of its contract. This of course does not mean that an MCO cannot institute rationing procedures to slow consumption or seek to interpret its contract to reduce the scope and extent of its legal obligations. But regardless of their ability to control resource consumption, MCOs are bound to live up to their contracts of coverage during their term of coverage.

Public health agencies, on the other hand, typically manage costs within global budgets, as supported by state, federal, and local categorical grants, as well as third-party payments generated by participation in state and private insurance programs, especially Medicaid. Because no individual is legally entitled to coverage, public health agencies can eliminate services and activities during a budget year if funds run out. Some states may in fact define certain public health agency duties as legally enforceable rights, thereby obligating the state to fund budget deficits incurred by the entitled service. But such a commitment on the part of state government is rare, and at the county level, even rarer.

Because public health agencies do not have legally enforceable duties to individuals, they also have greater latitude to commingle funds and engage in cross-subsidization practices in order to keep their basic activities afloat. Thus, for example, a public health agency may pool revenues derived from grants, contracts, patient fees and third party payments (most typically Medicaid) to support the provision of subsidized personal health care activities for the uninsured. In this way,

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[6] NCQA, *Medicaid HEDIS* (Washington D.C., 1996); Himmelstein DU, Woolhandler S, Bor DH. Can Medicaid managed care provide continuity of care to new Medicaid enrollees? an analysis of tenure on Medicaid. *Am J*

shortages in one area can be compensated for via budgetary reallocations of dollars where not prohibited by law. Because grant and contract funding for public health activities tends to be modest, and because a large proportion of the patient population is poor, third party revenues, especially Medicaid, take on crucial importance.

For the period 1991-93, on a national basis, local public health agencies derived an average 7 percent of their operating budgets from Medicaid revenues. There are, however, wide variations between states. The following table shows the allocation of sources of funds for local health departments for the four states in this study. The data are derived from the Urban Institute's *Assessing the New Federalism* project examining public health transformations in 13 states, using unpublished data from the National Association of County and City Health Officials. The author notes that one determinant of a local health department's reliance on Medicaid revenues is the extent to which it provides personal health care services:

> "The range for the average health department in the study states was 1 - 25 percent. On the low end were Massachusetts and New Jersey, most of whose local health units provide no personal health services. States with double-digit Medicaid shares were Alabama, Minnesota, and New York, where local health departments are significant providers of home health services (which likely accounts for a large fraction of their Medicaid revenues)."[7]

Sources of Funds for Local Health Departments, FY 1991, 1992, or 1993

State	Local [a]	State [b]	Federal [c]	Medicaid [d]	Medicare	Other [e]
California	26%	52%	6%	2%	3%	11%
Michigan	28	36	2	9	8	18
Minnesota	26	27	4	11	6	25
New York	27	26	3	18	14	12
U. S. Average	34	40	6	7	3	10

[a] Includes city, township, town, and county sources.
[b] Includes passthrough funds from federal government and excludes Medicaid.
[c] Includes federal monies that are paid directly to the local health department, excluding Medicaid.
[d] Includes federal and state shares of Medicaid.
[e] Includes private foundations, private health insurance, patient fees, regulatory fees, and other unspecified.

Public Health. 1998;88:464-466.
[7] Wall S. Transformations in public health systems. *Health Affairs.* 1998;17(3):72.
It should be noted that a variety of accounting practices may confound the understanding of a local health department's true "reliance" on Medicaid as a source of funding. For example, the Hennepin County Community Health Department (CHD) in Minnesota provides a significant amount of home care services to Medicaid-eligible persons; however it out-sources this work by contracting with private providers rather than by using employees of the department. CHD experienced a budget "loss" a few years ago, but it was strictly a change in accounting procedures. Previously, CHD paid vendors and billed the state Medicaid agency with Medicaid funds flowing through the CHD budget as a pass-through. The Medicaid agency subsequently decided to pay the vendors directly rather than through CHD, which still retains responsibility for negotiation and administration of the provider contracts.

Source: Wall S. Transformations in public health systems. *Health Affairs.* 1998;17(3):70.

C. Traditional World-View Perspectives

Differences in the traditional world-view perspectives of public health and managed care present complex challenges for understanding and collaboration. Managed care combines health care delivery with the financial and structural principles of insurance, which focus on traditional notions of coverage determinations and medical necessity, rather than the broader world-view of public health. Understanding how to meet the needs of members during the contract period within the constraints of fixed-price reimbursement, while still achieving an adequate profit margin or return on investment, shapes an MCO's focus on the present or short-range timeframes. Public health, by contrast, takes a longer view of achieving the goal of community health status improvement, which may take many months, or even years, to reach. Public health agencies must also be equipped to respond rapidly to disease outbreaks with short-term dedication of labor- and resource-intensive efforts to contain the spread of a particular disease. MCOs are an outgrowth of the world of employment-based health insurance. They gear their operations and activities to relatively healthy, relatively easy-to-manage patients. Public health agencies frequently specialize in the care, management, and oversight of complex patients who present management challenges that include the provision of social supports to ensure completion of treatment (e.g., transportation, translation, "cultural competency" capacity, etc.). A key question which is fundamental to any discussion of the possibility of public health and managed care collaboration, thus, is the extent to which each domain is aware of the other's perspectives and traditions.

II. STUDY DESIGN, QUESTIONS, AND RESEARCH METHODOLOGY

This project's conceptual focus is on the critical juncture between the principles and legal obligations of managed care and the duties of public health agencies to ensure the effective delivery of personal health services (particularly those that involve communicable disease) and fulfill their population-oriented health functions such as disease prevention and surveillance, quality of care oversight and regulation, contact tracing, and partner notification.

Researchers previously have noted the existence of contractual relationships between

public health agencies and managed care organizations,[8] but the nature of these MOUs has not previously been studied in a rigorous, in-depth manner. In 1996, the George Washington University conducted a pilot study of managed care/public health agency relationships in the area of tuberculosis in three communities.[9] Based on that study's findings, the CDC commissioned an expanded study of the use of MOUs or similar agreements using a wider range of communicable disease program areas. Specifically, the expanded study was designed to examine MCO/public health agency interaction in the areas of tuberculosis, sexually transmitted diseases, prevention of transmission of HIV,[10] and childhood immunizations, areas in which public health agencies historically have played both population-based and personal health care roles, serving both insured and uninsured populations. The study areas also reflect issues which had been identified, in a companion study undertaken by the University, as having received only limited attention in the master agreements between state Medicaid agencies and MCOs.[11] Of particular interest, therefore, was the extent to which MOUs could be used to address access, coverage, quality improvement, data reporting and other matters arising from the relationship of managed care to public health practice which are left unresolved in purchasing agreements.

While a fundamental goal of the study was to assess the effects of managed care on local public health agency activities, its central purpose was to explore the MOU dynamic. Thus, the research design for this study focused on the structure, process and outcomes of the MOUs: what they contained, how they were developed, the extent to which they led to MCO/public health agency relationships where few or none had previously existed, and their practical effects, especially in the area of communicable diseases. In addition, researchers gathered information to assess the effects of MOUs on public health agency revenues, information flow, and the use of standards of care. These issues are of central importance to MCO/public health agency collaboration.

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[8] Halverson PK, Kaluzny AD, Richards TB. Not-so-strange bedfellows: models of interaction between managed care plans and public health agencies. *op.cit.*

[9] Sofaer S, Woolley SF, Mauery DR. *Models for Assessing the Impact of Changes in Health Care Delivery and Financing On Community Tuberculosis Prevention and Control Programs*. Center for Health Outcomes Improvement Research, The George Washington University, Washington D.C. 1997.

[10] Specifically, the study considered interventions aimed at the prevention of vertical transmission of HIV (i.e., perinatal transmission from pregnant women).

[11] Rosenbaum S, Smith BM, Shin P, et. al. *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts.* CHPR, The George Washington University, Washington D.C. 1998.

Because of the importance of Medicaid to public health agencies, the focus of this study is on the use of MOUs as mandatory Medicaid managed care has grown. This project was designed to assess the ways in which contracts, memoranda of understanding, and similar arrangements facilitate the managed care public health relationship and the barriers and the facilitating factors underlying these collaborations. There were three critical cross-cutting analysis issues within this project: (1) the identification of information flows among multiple private and public stakeholders (e.g., health departments, MCOs, providers, and patients); (2) the presence and use of standards of care for the four program study areas (how they are defined, agreed upon and utilized); and, (3) the identification of changes in revenue streams within public health agencies as the financial structures of health care shift.

Following a series of reconnaissance interviews, the research group selected five sites where significant progress had been made in developing MOUs. Site visits, utilizing a case study methodology, were conducted in the Spring of 1997 in Onondaga County (Syracuse), New York; Hennepin County (Minneapolis), Minnesota; Detroit, Michigan; and Sacramento and Riverside Counties, California. The selection of sites was purposive rather than random. These were areas, given their population size and complexity, with measurably higher rates of communicable disease prevalence, and substantial enrollment of Medicaid beneficiaries and other affected populations in managed care. An additional important site selection criterion for this project was a high potential for effective public/private collaborations in light of a heightened degree of interest in managed care and public health on the part of the state agency with responsibility for managed care oversight and/or Medicaid managed care contracting. Personal interviews conducted with state and local health and Medicaid and MCO officials during the site selection process provided us additional information and confirmed their willingness to participate in the study.

Informants for sites visited for this study and a companion study described below were asked to supply the MCO/local public health agency MOUs or other written agreements that set forth the terms of their relationships with managed care organizations with regard to Medicaid MCO enrollees. Staff attorneys at the Center for Health Policy Research identified the major elements of these documents, set forth the elements in the matrix shown in Table 1, and analyzed the documents to determine whether and how each addressed these elements, as well as what broad public health elements were *not* addressed in these agreements.

Once the locations were selected as a study sites, researchers conducted a series of in-depth, semi-structured interviews with state and local Medicaid officials, state and local public health officials, and local MCO officials. Researchers collected aggregate epidemiological data on the four disease program areas to gauge prevalence and incidence. Also collected were aggregate data on managed care enrollment and market conditions in order to place the site in the context of managed care market penetration.

Interviews were conducted in the following professional domains: state-level Medicaid and public health; local-level public health; and managed care organizations. Interviewees were asked about their professional experience and positions, their views on Medicaid managed care, the development of MOUs between public health and managed care organizations, the impact of such agreements on the delivery of personal health services to individuals with communicable diseases, and the perceived impact of these agreements on population-based disease control policies and programs. Questions were designed to obtain information about how MOUs were developed (who was involved, what were the critical issues, over what period of time, etc.), where they were in the process, and what expectations interviewees had about the future for Medicaid managed care and the role of public health, especially in their own localities. Copies of the interview protocols appear in the Appendix.

The data collection process for this report used classic case study methodology. In the course of the site visits, the analysts began to surface the themes and patterns that were emerging in the interviews. Background primary source material was also collected.

III. ANALYSIS OF MEMORANDA OF UNDERSTANDING

A. Overview of Documents

Table 1 summarizes the elements of nine memoranda of understanding [12] and other written agreements that were analyzed by lawyers at the Center for Health Policy Research. Four of these documents were furnished for the sites visited for this study. An additional five written agreements were furnished for five other sites visited by research staff for a companion study, funded by the Henry J. Kaiser Family Foundation.[13] In that study, which focused on issues relating to sexually transmitted diseases (including HIV), researchers examined local public health agencies/MCO relationships under agreements that were already operative at the time of their site visit. Because combining both sets of MOUs permits broader analysis, all nine documents were analyzed for all elements shown in Table 1 and the results of the analysis are provided in this section. Findings from the STD-specific site visits, when analyzed, will become an additional section of this document.

The CDC Study Sites: At the time of the five site visits in Spring 1997, MOUs were operational in only one locality, Onondaga County, New York. In the other four sites, the agreements were still in some process of drafting or negotiation or were completed but not yet been signed. With one exception, the MOUs for the CDC study sites were developed in much the same manner. State health and Medicaid agencies in New York, Michigan, and California created model MOUs and templates as suggested guidelines for local public health agencies to use in crafting and negotiating MOUs with the MCOs operating in their areas. The variation among the California contracts suggests a substantial degree of local public health agency/MCO negotiation resulting in revisions to the basic, state-developed agreement.

Among the initial study states, California was the most advanced in its thinking about managed care's relationship with public health and in its press for MOUs. Beginning in 1995, Medi-Cal officials, responding to concerns raised by both state and local health officials and

[12] In 1996, the Minnesota legislature enacted legislation entitled "Collaboration Plan" (Minn. Laws, 1996, Ch. 451, Art. 1 §3) that requires managed care organizations to engage in service area planning and to make planning documents available for public input. The legislation is distinct from the MOUs and thus is not displayed on this table.
[13] Forthcoming.

others, issued an addendum to the Medi-Cal RFA that stipulated a "General Relationship Between the Plan and the LHD (local health department)" as a condition of contract award. As noted, the state also created sample MOU agreements and coordination matrices for use in the promulgation and development of local public health agency/MCO collaborations. The state provides additional detail for specific program areas such as TB, STDs, and immunizations by issuing "Policy Letters" that (at least in the state's view)[14] constitute addenda to the contracts between the MCOs and the state.

In Minnesota, by contrast, neither state health nor Medicaid agencies developed model agreements. Instead, the state legislature enacted legislation that required MCOs to engage in a planning process within their service areas that took into account community health needs from a list of 17 public health goals and permitted public input.[15] The legislation specified no required areas of collaboration between MCOs and local public health agencies, nor did the state health or Medicaid agencies develop a standard provider agreement.

The Kaiser Foundation Study Sites: In contrast to the CDC study sites, the documents collected for the STD site visit study were in effect at the time of the site visit. In one instance, Marion County, Ohio, the basic agreement dated from 1985, when the county health agency entered into generic, commercial provider agreement with MCOs participating in a predecessor to the current Ohio Medicaid managed care program.

The process of developing the service agreements for the Kaiser STD study sites was more varied than with the CDC study sites. In one state, Delaware, the state agency had drafted the agreement and was also the contracting party, rather than local health agencies.[16] In a second state, Texas, the county health department had drafted the document. In a third state, Oregon, the basic agreement had been drafted by a state-wide association of county health agencies for use by its members. In two states, the agreement was a generic provider agreement; in one instance, Ohio, with a 3-page addendum setting out rates of payment for services to be furnished by the health agency. The Tennessee document was also a standard commercial primary care provider

[14] It is unclear whether the plans themselves would recognize these letters as legal, unilateral modifications to the contract.
[15] Minnesota Statutes 1996, Chapter 62Q.075, "Local public accountability and collaboration plan."
[16] Local health agencies in the 3 counties in Delaware are administered by two "State Services Divisions", one for the northern part of the state and the other for the southern part. They are part of the state Department of Health and Social Services, not units of county government.

agreement, which was used in lieu of a different, model agreement that had been drafted by the state public health agency.

B. Findings from MOU Analysis

As Table 1 indicates, the MOUs share certain common characteristics, particularly in the case of the California documents, where, as noted, a state model exists for use by local public health agencies. The documents which were reviewed frequently are labeled "model agreements" or "standard agreements." Thus, it is not possible to determine whether actually executed documents between MCOs and local public health agencies either do (or will, when finally executed) share all of the features of the models on which they are based. Standard contracts frequently are modified in certain respects to meet the terms of a specific agreement. However, while it is not uncommon for an executed agreement to depart from a standard document, the model MOUs nonetheless are highly instructive, since, as legal instruments they reflect how the drafters, including but not limited to the local public health agencies, conceive of the local public health agency/MCO relationship. Thus, the documents are important as a means of identifying the issues and relationships that public health agencies consider to be part of an agreement between a local public health agency and a managed care organization.

Table 1: A TYPOLOGY OF MEMORANDA OF UNDERSTANDING BETWEEN PUBLIC HEALTH AGENCIES AND MEDICAID-SERVING MANAGED CARE ORGANIZATIONS (MCOs)

√ = document contains any language addressing the issue. Does not denote that issue is addressed in a particular manner.
*Agreement specifies that a specific enumerated issue will be addressed in a separate document, to be developed.
** Agreements were operational at the time of the site visits.

ELEMENTS OF MOUs	Onondaga County, NY[17] **	Sacramento County, CA[18]	Riverside County, CA[19]	Detroit, MI[20]	New Castle, Kent, and Sussex Counties, DE[21] **	Mont-gomery County, OH[22] **	Marion County, OR[23] **	Shelby County TN[24] **	Harris County, TX[25] **
1. GENERAL									
Medicaid agency/MCO contract or RFP addresses public health agency agreement	√	√	√	√	√	√	√	√	√
Contract /RFP requires agreement		√	√				√		
Contract /RFP provides authorization and/or incentives for agreement	√[26]			√	√	√[27]			√[28]
Non-contract incentive for agreement								√[29]	
Contracting public health agency is									

[17] Public Health-Managed Care Partnership Agreement between Onondaga County and Managed Care Plan
[18] Draft Medi-Cal Managed Care Agreement
[19] Agreement between Molina Medical Centers and Riverside County Health Services Agency
[20] Detroit Health Department, Model Fee for Services Agreement with Qualified Health Plans
[21] Master Agreement Between Delaware Division of Public Health and MCD Health Services Corporation: First State Health Plan
[22] Participating Provider Agreement with Reimbursement Schedule (Attachment C) setting forth reimbursement rates for specified services furnished to both Medicaid *and commercial* enrollees by the Communicable Disease Clinics of the Combined Health District, Montgomery County
[23] HMO [omitted word(s)] Medical Services Agreement
[24] Blue Cross and Blue Shield of Tennessee Group Practice Agreement (includes Attachment BLUECARE Group Practice Primary Care
[25] Agreement between “Alpha Texas, Inc.” and Harris County (“Alpha Texas, Inc.” is a pseudonym used for demonstration purposes in the model agreement.)
[26] The New York RFP states that "preference" will be shown in awarding of Medicaid managed care contracts to MCOs that "offer contracts to such traditional providers" as public health departments; New York site visit informants indicated that such contracts were required, but the source of the requirement is unclear.
[27] Ohio site visit informants identified an enrollment performance standard in the Ohio Medicaid managed care contract as a key factor in establishing agency-MCO agreements. The standard requires that MCOs enroll at least 15% of a county's Medicaid eligibles (10% in smaller counties) by June 30, 1998 or lose eligibility to continue serving Medicaid enrollees.
[28] Texas site visit informants identified a preference in the procurement for process for MCOs that included local health agencies in their provider networks as a key factor in establishing agency-MCO agreements.
[29] Tennessee site visit informants identified legislative diversion of $15 million annual state funding for public health functions as a key factor in the state health department decision to seek agency-MCO agreements.

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Local agency	√	√	√	√		√	√	√	√[30]
State agency					√				
Basic agreement drafted by:									
Public health agency	√	√	√	√	√		√[31]		√
MCO						√		√	
2. BENEFITS AND SERVICE DUTIES									
Services for specified populations/diagnoses/conditions	√	√	√	√	√	√	√	√	√
Children with special health care needs	√	√	√		√	√			
Early intervention programs/ programs for children with developmental disabilities	√				√				
Family planning services	√	√	√	√	√	√	√	√	√
Hepatitis B screening of pregnant women	√							√	√
HIV/AIDS	√	√	√		√		√	√	√
Lead poisoning control	√	√						√	√
Neural tube defects/ spina bifida	√								
Other communicable diseases	√	√	√	√	√		√	√	
Pediatric and adolescent health services; EPSDT	√	√	√	√	√		√	√	√
Perinatal services	√		√	√	√		√	√	√
Pharmacy services				√	√	√		√	√
Refugee health care		√							
School health services	√			√				√	
Sexually transmitted disease	√	√	√	√	√	√	√	√	√
Substance abuse				√					√
Tuberculosis	√	√	√	√	√	√		√	√
Vaccine-preventable diseases (immunization services)	√	√	√	√	√	√	√	√	√
WIC	√	√	√						√
Medical necessity determinations or prior authorization for public health	√				√	√	√	√	√

[30] Harris county contracts with the MCO to furnish services through the county health department.

[31] The local health agency used a model contract drafted by the state Council of Local Health Agencies.

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services									
By MCO					√	√	√	√	√
By public health agency	√								
3. NETWORK STANDARDS									
Network status of public health agency	√	√	√	√	√	√	√	√	√
Use of certified laboratories & reporting of data to public health laboratories		√	√				√	√	
4. ACCESS MEASURES									
Confidentiality of care			√		√	√	√	√	√
Member outreach, education	√		√		√	√			√
By MCO	√		√						
By public health agency	√		√		√	√			√
Parental consent for services									√
Referral	√	√	√	√	√	√	√	√	√
MCO member self-referral to public health agencies	√	√	√	√	√	√		√	√
MCO provider referral to public health agency	√	√	√	√	√	√			√
Public health agency to MCO	√	√	√	√	√		√	√	√
5.QUALITY ASSURANCE /PERFORMANCE MEASUREMENT									
Education of network providers on public health issues and services	√		√						√*
By MCO	√		√						
By public health agency	√		√						√*
Participation in infant mortality/morbidity reviews	√								
Quality performance standard setting & performance measurement	√		√	√		√	√	√	√
MCO use of public health service standards for one or more diseases	√		√					√	

* The documents address health agency education of "medical providers and hospitals in the community" without specifically addressing education of MCO network providers.

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Public health agency monitoring of MCO provider performance			√						
6. RECORD STANDARDS /REPORTING DUTIES									
Access to books/records	√	√	√		√	√	√	√	√
Of public health agency			√		√	√	√	√	√
Of MCO	√	√					√		√
Access to sharing of data		√	√						
By MCO		√	√						
By public health agency			√						
Data reporting by health agency	√	√	√		√	√		√	√
Care furnished and /or follow-up of member health care needs	√	√	√		√	√		√	√
Data reporting by MCO	√	√	√		√		√		
Notifiable diseases	√	√	√						
Care furnished and /or follow-up member health care needs	√				√		√		
VFC data		√	√						
Provision of immunization records to members		√	√						
By MCO		√	√						
By public health agency			√						
7. POPULATION-BASED ACTIVITIES									
Cancer epidemiology	√								
Development of service area immunization plan				√					
By MCO				√					
By public health agency									√*
MCO relationship to VFC: Program Participation by MCO providers		√							
Participation in immunization registries/tracking systems		√	√	√					√
By MCO		√	√	√					
By public health agency		√	√						
Partner/contact notification and disease surveillance	√	√	√		√				√
By MCO		√							

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By public health agency	√	√	√		√				√*
Service area needs assessment	√								√*
By MCO	√								√
By public health agency	√								
8. BUSINESS RELATIONSHIP									
Indemnification	√	√	√			√	√	√	
MCO duty to indemnify	√	√	√			√	√	√	
Public health agency duty to indemnify	√	√	√			√	√	√	
Liaisons and Meetings		√	√						
MCO duties		√	√						
Public health agency duties		√	√						
Medicaid eligibility determination/MCO enrollment		√				√	√	√	√
MCO payment to public health agency	√	√	√	√	√	√	√	√	√

√ = document contains any language addressing the issue. Does not denote that issue is addressed in a particular manner.
Agreement specifies that a specific enumerated issue will be addressed in a separate document, to be developed.
** Agreements were operational at the time of the site visits.

The analysis of the MOUs support four major findings:

1. MOUs as Classic Provider Agreements

To a significant degree, MOUs are in fact designed to function as would any service agreement between a managed care organization and a network provider. In other words, the documents function as typical managed care network provider agreements; they set forth the manner in which public health agencies will supply health services to managed care organizations so that MCOs can carry out their contracted duties.[32] As would be the case with any commercial provider network agreement, many of the MOU provisions relate to the business relationship between the parties. Indeed, many of the clauses found in the MOUs are identical in general purpose and structure to those found in standard commercial network agreements.[33] Examples of standard business provisions found in the MOUs are clauses relating to the indemnification of the parties in the event of a liability ruling, severability, contract terms, scope of covered services, dispute resolution procedures, and the timing, manner and nature of payments that the MCO must make to the health agency.

2. MOUs as Applicable to All Books of Business

Most of the MOUs were structured to apply to all managed care enrollees, not merely those who are Medicaid-sponsored. While Medicaid requirements or incentives may have triggered the MOU process, the structure of most of the agreements resembles any network provider agreement and should be equally transferable to any book of business. Because the contracts are not necessarily limited to a specific book of business of the MCO, they can cover members from any plan offered by the MCO to any purchaser, Medicaid, employer, or otherwise. Indeed, the Ohio document specifically references its applicability to all members of any plan offered by the MCO, not merely its Medicaid enrollees. This is consistent with provider network

[32] For an overview of agreements between managed care organizations and providers see: Rosenbaum S, Silver K, Wehr E. *Principal Findings from an Analysis of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Programs,* (DHHS, SAMHSA, June 1997.)
[33] *Ibid.*

contracts previously examined by CHPR staff, which are typically drafted in generic terms and applicable to any product line offered by the MCO to its buyers.[34]

3. MOUs as Reflective of Managed Care, Not Public Health, Imperatives

The MOUs are based on the imperatives of managed care, not public health. Because the MOUs are structured to function much like any traditional provider network service agreement, they address only to the most limited degree (and frequently not at all) MCOs' obligations to local public health agencies that arise from the needs of public health, rather than the managed care business relationship (e.g., the local public health agency's rights as a member of the MCO's provider network). In other words, despite the extraordinary impact that managed care has on public health functions, the MOUs do not function as a means of addressing these issues. For example all of the agreements identify personal health services that health agencies will furnish to members of the MCO and the terms under which the MCO will pay for care. While most of the agreements (seven out of ten) require the agency to report data on services furnished to members, only three require the MCO to furnish data to the public health agency. In only one case (Onondaga County) does the MOU reserve for the health agency any role in public health treatment decision-making (e.g., the extent to which the MCO will provide or pay for certain types of contract treatment essential to public health, such as treatment of persons with active tuberculosis). Similarly, only one MOU (Detroit) identifies whether or the extent to which MCOs will participate or in any way assist in community-wide planning, service delivery, partner notification, or population surveillance activities.

To be sure, many of these issues may arise during the negotiations over the MOUs and may in fact result in informal "side agreements." However, they are not a formal part of the MOU, nor are they enforceable. Moreover, even when a public health agency retains sole responsibility for a particular activity (e.g., partner notification) the agency would depend on information from the MCO and its provider network regarding the presence of an STD that should trigger the partner notification process.

4. Similarities and Differences Among MOUs

[34] *Ibid.*

The documents are both consistent and variable at the same time. Nearly all agreements reflected the health agency's view of the importance of continuing to furnish plan members with certain personal health services that are covered by the MCO contract and essential to public health (e.g., family planning, immunizations, screening and treatment for STDs, treatment of tuberculosis, and services related to HIV). Moreover, since these services show up in both the pending and signed agreements, they reflect a view on the part of the MCO that public health agencies do, indeed, have a role to play in the provision of personal health services, whether for Medicaid beneficiaries or other members.

As the same time, the contracts vary greatly in the range and scope of services they cover, a fact which probably is driven as much by the uniqueness of local health agencies as the purchasing expectations of the MCOs. Table 2 presents examples of the variation in the manner in which contracted service duties are described under the agreements. STD-related services are used as the example to illustrate this variation. For example, the Sacramento County model MOU contains extensive documentation related to how health plans and the public health agency should relate to each other in the area of STD prevention and treatment. The excerpted language sets out five pages of relationship elements covering the use of liaisons by the plan and the agency, access to care, confidentiality, disease reporting, provider payment, coordination of care, and coverage of diagnostic and treatment services for individual STDs. The Riverside County agreement contains shorter STD provisions that are less detailed than those found in Sacramento and address fewer issues. While the California documents contemplate payment for STD services, the Onondaga County MOU specifies that the county "will bill neither the plan nor Medicaid for STD services." Similarly, while the Onondaga County agreement contemplates that the county will develop practice standards in the areas of screening and treatment for MCO network providers, this role is not identified in the California documents.

Four agreements address activities related to sexual contacts of MCO members diagnosed with an STD, but the roles and responsibilities of the parties differ. The Onondaga County agreement assigns follow-up duties to the public health agency. The Sacramento County contract specifically obligates the MCO to inform its network providers about notification duties. In these sites, local practice patterns and public health agency preferences lead to this variation, yet all contracts address the issue of STD services in one manner or another.

In short, the contracts by and large memorialize the relationship of the parties around those public health agency functions that relate to the provision of personal health care for which the MCO is contractually responsible. They do not address the MCO's duties toward the public health agency in areas of traditional public health, such as surveillance activities, analysis of population health, contact tracing, partner notification, and so forth, for which the public health agency remains responsible. MOUs thus are used to memorialize relationships around matters that insurers have contracted to undertake, not around functions that local public health agencies are obligated to perform for all community residents including members of the plan. These agreement focus on those activities by local public health agencies that aid insurers to immediately meet their contractual obligations, rather than those activities that local public health agencies are inherently obligated to, but cannot, meet without MCO cooperation.

Table 2: SERVICES RELATING TO SEXUALLY TRANSMITTED DISEASES IN AGREEMENTS BETWEEN MEDICAID-SERVING MANAGED CARE ORGANIZATIONS AND PUBLIC HEALTH AGENCIES

[*Note.--Emphases added*]

Onondaga County, NY	"…County will provide STD services at patient's request without seeking prior authorization from the Plan. County will continue to provide direct clinical services through its County STD clinics. The County shall make all reasonable efforts, consistent with current law and regulations and with patient consent, to report confidential reports to the Plan and inform the patient of the availability of STD services in-plan…[and provide services as set forth in attachment, which addresses a) appointment of plan and health department liaisons; b) *health department provision of STD services, without charge to patient or to plan*; c) plan duties to "[e]encourage all members to seek STD services at their plan or from County STD clinics [and to not require prior authorization or restrict the number of visits needed for outpatient or inpatient diagnosis, treatment and counseling]; d) *plan duties to provide to health department completed STD disease-reporting forms , ensure laboratory reporting and "educate" plan providers regarding "the need to provide OCHD with information on STD patients and/or partners of STD patients*; e) plan duty to "develop and implement STD screening and treatment protocols based on State and County recommendations "and *report "non-compliant" patients to health department*; f) health department duty to furnish :"protocols and procedures for the evaluation of partners of STD-infected members [and] [p]rovide follow-up of contacts for all STD patients; and g) provision of medical and public health consultation by health department, and plan duties to inform providers of availability of such consultation.]"
Sacramento County, CA	[Plan responsibilities (set forth in matrix) include]: "implement[ing] procedures to ensure that Members have prompt access to appropriate STD prevention, screening, counseling, diagnosis and treatment services…[and to] allow members to access STD services by selecting a provider other than the member's PCP if he/she desires confidentiality…[and to] allow minors aged 12 and older to access STD services without parental consent…[and to protect member confidentiality]. [also to] *provide COUNTY with completed California Morbidity Reports (CMRTs) on patients with reportable diseases…Implement procedures to monitor compliance of PLAN providers of STD services with communicable disease reporting requirements. Ensure the PLAN's clinical laboratories provide COUNTY with required information on patients with reportable STDs*…Reimburse…COUNTY for the diagnosis and treatment of [specified] STDs…*Inform PLAN providers regarding the importance of rapidly notifying sex partners* of infected PLAN Members so they can be tested and receive appropriate counseling and treatment at the earliest opportunity. Forward medical documentation to the PCP….[and matrix with definitions of reimbursable services per episode of specified STDs]
Riverside County, CA	"….*MMC providers and RCHSA shall utilize current STD Guidelines from the U.S. Public Health Service in the diagnosis and treatment of sexually transmitted diseases* [health department duty to furnish updated guidelines; plan duty to disseminate such guidelines to plan providers]; …[plan members may use health department STD services without prior authorization and plan will inform members about access to STD services including minor access to STD services without parental consent]… *RCHSA is an out of plan provider treating STDs* within its scope of practice [and will provide outpatient STD services for plan members for specified conditions] RCHSA will coordinate with MMC or the member's assigned primary care physician, if known, for authorization and referral for specialty care, contingent upon consent by the plan member [and will refer members to MMC provider for follow-up and non-STD related care]… RCHSA will request that plan members sign a release of confidential information. Upon consent, RCHSA will provide medical records to MMC…MMC will reimburse RCHSA for STD services to plan members based on specific STD diagnosis and service definitions as follows ["episodes" of specified conditions defined for purposes of reimbursement, e.g., "Gonorrhea, Non-Gonococcal Urethritis and Chlamydia -- Can often be presumptively diagnosed and treated at the first visit, often with single-dose therapy. for individuals not presumptively treated at the time of the first visit, but found to have gonorrhea or chlamydia, a second visit for treatment will be reimbursed…"] RCHSA is responsible for conducting case contact investigations, including the assurance of appropriate treatment, when indicated… *MMC providers will cooperate with RCHSA in the screening and treatment of plan members who are contacts of confirmed STD cases and will*

	assist with compliance related activities concerning the treatment of members for STDs."
Detroit, MI	"…The areas of health care service identified for coordination and collaboration between the DHD and the QHP are as follows: Communicable Disease STDs… SCOPE OF SERVICES DHD Pursuant the coordination and collaboration requirements of the QHPs contract with the Michigan Department of Community Health, the DHD, a local health department, agrees to provide the QHP [with] the following services:… Sexually Transmitted Diseases. Provide communicable disease health services, including invoices, reports, testing (including laboratory testing), evaluation, treatment and follow-up treatment for all QHP enrollees seen at any DHD clinic which treats Sexually Transmitted Diseases, whether by referral or walk-in appointment…. OBLIGATIONS OF QHP… Sexually Transmitted Diseases. Honor health care service and pharmaceutical invoices from DHD for all QHP enrollee's [sic] who seek Sexually Transmitted Disease testing (including laboratory testing), evaluation, treatment and follow up treatment at any DHD clinic which treats Sexually Transmitted Diseases, whether by referral of [sic] walk-in appointment…. Health Plan Services….. b. STD Screen to identify high risk enrollees seen for prenatal, family planning, substance abuse, tuberculosis and emergency services and for high risk patients seen through other plan services. Provide, authorize or contract for adequate counseling, diagnosis and treatment according to state and federal guidelines. Provide disease and prevention education to all high risk enrollees."
New Castle and Sussex Counties, DE	"Early Intervention and Engagement… The service provided is the assessment of the immediate presenting need, and the treatment of that need. Assessment includes assessment of related risk and follow-up. Health education related to the presenting need and associated risk is provided… the managed care plan and the assigned primary care physician are identified. the patient is asked about their reasons for seeking care at public health and is encouraged to follow-up care with the assigned primary care physician… Typical presenting needs and associated early intervention and engagement are in response to:… Infectious Disease (e.g., STDs,…)… Services include appropriate history and physical, limited treatment of the presenting acute problem, ordering any needed diagnostic tests, health education, risk reduction and self-care information, *reporting as required for infectious disease*, and as appropriate to the primary physician, and referrals to other providers or social services."
Montgomery County, OH	"Sexually Transmitted Disease Services… Office visits assessment, diagnostic services and treatment of all sexually transmitted diseases(which includes medications and lab tests)$25.00 Return office visits within 6 months with same diagnosis (which includes medication and lab tests) 10.00 Return visit within 6 months with different diagnosis (which includes medication and lab tests) 15.00"
Marion County, OR	"…COUNTY [LHD] and its employed health care professionals may provide the following Medically Necessary Services within the scope of licensure or certification of COUNTY's employed health care professionals:… 2. Diagnosis and treatment of sexually transmitted diseases… All services will be provided according to the Office of Medical Assistance programs' practitioner's Handbook for Medical-surgical Services, January 1995, and associated amendments…"
Shelby County, TN	"…Covered services…include:… 3. HIV, STD and TB testing and treatment…"

Harris County, TX	"…Laboratory tests [for prenatal clients] include…RPR, Hep. B. surface Antigen (HbsAg), chlamydia…Individualized education on HIV and syphilis during pregnancy are addressed and appropriate testings are offered with the patient's consent. …Services in the Family Planning clinic include…laboratory tests including…Chlamydia…Syphilis…HIV prevention counseling, testing, partner elicitation, education… …[at local public health agency STD clinic] Laboratory testing for Syphilis is performed on site for immediate treatment. In addition to examinations and treatments, Clients are educated about risky behavior, disease transmission, protocols for prevention, symptoms and medical management of infections and they also receive educational material, non-judgmental counseling, and confidential HIV counseling and testing."

IV. Results from Site Visits

A. Overview of Study Sites

The visits for the CDC-sponsored phase of the project occurred during May and June, 1997. At this time all of the study states had instituted mandatory managed care in some or all portions of the state, primarily for the AFDC-related population of low income women and their children. However, with respect to the sites, the market maturity, penetration, variety, and stability of each MCO varied considerably, as did the MCOs' experience with Medicaid enrollees. MCOs ranged from small local Medicaid-only MCOs to large non-profit and for-profit MCOs with commercial operations across wide geographic areas.

Collaborations between local public health agencies and MCOs were mandated in three sites (Onondaga County, New York, Sacramento County, and Riverside County, California) and highly encouraged in two sites (Detroit, Michigan and Hennepin County, Minnesota), and ranged from very tightly to broadly defined. Moreover, as would be expected given the local nature of public health, there were significant differences in how the local public health agencies perceived their missions, ranging from focus on the delivery of the core public health functions of policy development, assessment, and assurance to the delivery of personal health services, including primary care, to their communities (with various blends of these two). MCOs also varied in how they defined their missions, from financial managers of an insurance product to integrated service delivery systems, again with blends of the two approaches in some instances.

The following discussion highlights the distinguishing features of each site and sets the context for our discussion and recommendations.

Onondaga County, New York: This 780-square-mile county is located in central upstate New York with Syracuse as its largest city. Comprising about 500,000 people, there are large tracts of rural areas and pockets of both urban and rural poverty. The county's population is primarily Caucasian, with African Americans accounting for 8% of the population. There is a small and growing population of immigrants and refugees from southeast Asia, eastern Europe, and the Caribbean.

The Onondaga County Health Department (OCHD) has largely moved out of the business of directly providing primary care services to focusing on the delivery of specific program area

services such as communicable diseases and maternal and child health and the fulfillment of the core functions of public health.

At the time of our visit, upheaval in the managed care market threatened to delay the start of the mandatory enrollment date. This upheaval was caused largely by MCOs' assertions (subsequently borne out in some cases) that they would leave the Medicaid managed care market or cap Medicaid enrollment as a result of premium reductions by the state. In general, managed care in New York, particularly upstate, had a relatively short history and thus had achieved relatively low market penetration. Both MCO and OCHD officials stressed the importance of learning from each other, as well as fostering an overall atmosphere of cooperation. Local officials predicted mergers and acquisitions of smaller firms by other regional New York firms to consolidate market share and expand enrollee bases. Indeed, this happened during our visit when Prepaid Health Plan announced its merger with HealthCarePlan and Independent Health, two Buffalo-based MCOs. The strategy of OCHD was to continue to develop MOUs with entities as they emerged.

Hennepin County, Minnesota: Located in southeastern Minnesota, Hennepin County is the most populous of Minnesota's 87 counties. With just over 1 million residents, it accounts for about 24% of the state's population. Hennepin County has the highest per capita income in the state and its largest city is Minneapolis. County residents are primarily U.S.-born Caucasians who enjoy overall good health. However there is a significant and growing minority population of immigrants and refugees, as well a small and important African-American community. The general economic health of the county and its many employment opportunities make it attractive to foreigners seeking secure living arrangements.

As in Onondaga County, the Hennepin County Community Health Department (CHD) has largely moved out of the business of directly providing primary care services to focus on the delivery of specific program area services such as communicable diseases and maternal and child health and the fulfillment of the core functions of public health.

Managed care has had a long history in the state, with high levels of market penetration in urbanized areas such as Hennepin County. The market is fairly stable and characterized by a somewhat insular "friendly competition." Officials credited these factors as greatly important in their understanding of what strengths managed care can bring to serving the needs of Medicaid-

eligible persons. As noted, the Minnesota legislation requires MCOs to engage in local planning activities known as "Collaboration Plans." However, most interviewees felt that the process was at the time too vague and open-ended to be of much practical use. On the other hand, Hennepin County is itself extensively involved in the managed care market, operating its own county-sponsored HMO, Metropolitan Health Plan, which competes with other MCOs for Medicaid business. At the time of the site visit, Hennepin County was moving toward a takeover of the Medicaid managed care purchasing process itself in order to gain greater control over this portion of the managed care market.[35] By 1997 the Hennepin County Health Department had in fact entered into provider agreements with MCOs in the county, including the county-sponsored plan.

Detroit, Michigan: The largest city we visited, with just over 1 million people in the city proper and over 4 million people in the metropolitan area of three neighboring counties, Detroit is composed of largely minority residents, primarily African American, not atypical of many inner city localities. The economic vagaries of the automotive industry, among others, have created pockets of both extreme poverty and great wealth. The Detroit Health Department's (DHD)'s clinics provide or arrange for both primary and specialty personal health services to low-income populations through a network of six primary care clinics serving primarily low-income publicly insured and uninsured people. Two of the clinics operate under contractual staffing arrangements with the Henry Ford Health System (HFHS), which owns the largest MCO in the area, Health Alliance Plan (HAP). DHD plans to continue operating these clinics, with financing coming from two sources: 1) public and private grants to support both primary and specialty care services for indigent and uninsured clients; and 2) Medicaid revenues generated through managed care participation to the maximum extent possible under provider network agreements. Medicaid patients of the health department who do not elect to use one of the county health department sites as their primary care provider will be referred back to their own primary care providers when attempting to utilize services out-of-network.

Sacramento County, California: This county is one of two in the state (San Diego is the other) to pilot a form of Medicaid managed care known as "Geographic Managed Care (GMC)."

[35] For a complete discussion of county-based purchasing of Medicaid in Minnesota, see: _____, State-county joint purchasing options for publicly funded health programs in Minnesota: a report of the findings of the Seven Metro County Direct Contract Steering Committee. February 14, 1997. Available at http://www.co.hennepin.mn.us/hpc/jporeport/jpo.htm. Accessed September 8, 1997.

The GMC model allows for multiple plans to bid for and receive contracts to cover Medicaid eligibles. At the time of the site visit, six MCOs had Medicaid contracts to cover upwards of 150,000 eligibles in Sacramento County.

Riverside County, California: While Sacramento County utilized the GMC model for Medicaid managed care, Riverside County was one of twelve California counties involved in what is known as the "Two-Plan" model. Under this model, Medi-Cal eligibles choose between a locally-organized health initiative (LI) and a commercial plan (CP). The LI for Riverside County is Inland Empire Health Plan (IEHP), a plan that originated from and was built around contracts with a number of local physicians and clinics, most of whom had prior experience with the local Medi-Cal and other low-income populations. The CP awarded a contract by the state for Riverside County is Molina Medical Centers (MMC), a minority-owned and -operated health plan which enrolls publicly insured patients almost exclusively. Riverside County was similar to Detroit in the concerns raised by county officials regarding MCOs' ability to meet all of the personal health care needs of county residents. Local public health officials continued to see a need for a significant public health presence in personal health care delivery for both uninsured and Medi-Cal eligible residents. Riverside County negotiated an MOU with IEHP in 1996 and was in the process of developing a draft agreement with MMC at the time of the site visit. One interesting dynamic at work was that the CEO of IEHP was formerly the Public Health Officer for Riverside County and had contributed to the design of the state-level templates for MOUs. He also has taken a lead role in attempting to ensure that traditional safety net providers not be lost in the move to Medicaid managed care and was an early proponent of the LI approach.

B. Key Findings from Site Visits

1. FROM EXPECTATION TO REALIZATION: THE EMERGENCE OF PUBLIC HEALTH AND MANAGED CARE RELATIONSHIPS

The establishment of working relationships between managed care organizations serving Medicaid beneficiaries and local public health agencies depends on expectations of the various parties with an interest in such relationships. Public health agencies may expect such relationships to be responsive to their public health obligations under state law and the terms of their grants for public health activities. Such public health expectations may be articulated in state statute or

regulation mandating some type of relationship between MCOs and local public health agencies, in other documents and policy statements developed by state agencies, or may be determinable only by interviews with key informants, as reported below.

Medicaid agencies and MCOs may have narrower expectations, reflecting their interests and duties as purchasers and sellers respectively of health care services for Medicaid beneficiaries. The master service agreements between agencies and MCOs are the primary source of information about expectations of these parties.

Medicaid Agency Expectations: As shown in Table 1, in all states studied except Ohio and Tennessee, the master service agreement between state Medicaid agencies and MCOs specifically addressed some type of relationship between the MCO and local health departments. Two of the states (California and Oregon) required MCOs to enter into subcontracts with local public health agencies as a condition of participation in the state's program; however, an MCO unable to meet this requirement could instead show evidence of "reasonable efforts" to achieve such agreements (California), or demonstrate to the state agency that an agreement was not feasible (Oregon). Other states recommended or authorized such agreements (Delaware, Michigan) or provided for "preference" in the plan selection process for MCOs that "offered" a subcontract to a "traditional provider" (defined to include local public health agencies) (New York, Michigan). Two states (Michigan, Texas) included minimal master contract standards for local public health agency participation in MCO networks, implying MCO discretion in inclusion of local public health agencies in their networks.

Almost without exception, the arrangements described in the master contracts did not address broad public health objectives. Instead, master contract language focused on conventional relationships in which the local public health agency would furnish personal health care services to MCO enrollees in return for MCO payment to the local public health agency. The fact that the Medicaid managed care contracts rarely referenced local public health agency functions other than provision of certain personal health care services may mean that the Medicaid agencies themselves are not familiar with local public health agencies except as one of several classes of "traditional providers" to which the agency has paid claims for services. It also reflects the level of involvement by state health departments in crafting the RFP specifications, which was

reported to be limited. In entering into local public health agency provider service agreements that do not address most public health issues, MCOs in most of the states are performing in accordance with relatively limited Medicaid agency expectations about the local public health agency/MCO relationship.

An exception to the typical master contract language was the Delaware RFP which stipulated that the MCO:

> "…should develop a Memorandum of Understanding with DPH county services that defines communication and coordination between public health and primary care providers regarding community outreach and family support services, assistance to enroll potentially eligible people into Medicaid and to provide continuity of care during times when Medicaid eligibility is discontinued. DPH has a significant role in the overall health care system. *The core public health functions to be considered by MCOs as they develop their responses are described the [sic] Association of State and Territorial Health Officials (ASTHO) document in Appendix I.*" (*emphasis added*)

The referenced ASTHO document briefly identifies a series of "core public health functions" (e.g., "prevents epidemics; monitors the health condition of the population; mobilizes communities for action") in language that is so general that it is difficult to imagine reducing it to specific, legally binding obligations for an MCO and a local public health agency. In fact, the written local public health agency/MCO agreement provided for the site visit in this state did not address the topics identified in the ASTHO attachment.

State Health Department Expectations: As previously mentioned, one reason the master service contract language reflected a limited vision of the public health role of MCOs was the narrow involvement of state health department officials in crafting the Medicaid contract language. In most of the study sites, interaction was modest. Interviewees in several states attributed this to diverse factors, including: 1) organizational, philosophical, and cultural "divides" between these state-level agencies that impeded communications; 2) the speed with which the specifications needed to be developed prohibited the use of a multi-sector consensus development process; 3) policymakers' desires to avoid overly prescriptive language that would impose state-level mandates on local health agencies that may not be responsive to local conditions; 4) the lack of public health expertise in Medicaid agencies and the lack of Medicaid expertise in public health agencies; and 5) the lack of managed care expertise in both Medicaid and public health agencies. In some states, such as New York and Michigan, the state health agency and the Medicaid agency

had only recently been reorganized under a single departmental organization, and employees were in the process of discerning new divisions of roles and responsibilities, communication lines, and overcoming the barriers of organizational "firewalls" that had previously divided them.

California presents a striking distinction to this general pattern. George W. Rutherford, MD, who at the time that the MOU requirements were first included in the California RFPs, was the Deputy Directory for Preventive Services in the California Health and Welfare Agency. Dr. Rutherford played a pivotal role for the state health agency in representing public health interests. This elevated role can be attributed to his previous experience as the State Epidemiologist as well as to his extensive contacts with both health and Medi-Cal officials. Dr. Rutherford was asked by Medi-Cal officials to participate in their Medicaid managed care working groups that examined clinical preventive services, the future of public health, basic benefit packages, and cultural competency issues. The first two of these groups provided the appropriate forums for Dr. Rutherford to put forward his ideas for MOUs as a means to put "glue" into the process of addressing access, quality, and cost, to improve the overall health of the public.[36] Cross-domain expertise and communication were highly valued in this environment, and Dr. Rutherford provided the necessary energy to bridge organizational and philosophical divides.

Subsequent to the release of the Medicaid master contract RFPs, state health departments took an active role in creating and disseminating recommendations for areas of potential collaboration between local public health agencies and MCOs. State public health officials in California, New York, and Michigan, for example, created legally non-binding matrices and templates that delineated these recommendations with suggested divisions of responsibilities. Examples of these matrices and templates appear in the Appendix. While the language in these templates is more comprehensive than that of the master service contracts, it still tends to be open-ended and relatively non-directive with respect to the public health duties of MCOs. Consistent with Medicaid contract language, the templates outline collaborations around three primary aspects of local public health agency/MCO relationships: 1) continued access to local public health agency services by Medicaid managed care enrollees; 2) reporting requirements of communicable diseases by MCOs and their providers; and 3) definition of standards of care to be utilized in the provision of services. In some instances, the matrices recommend, but do not

[36] Rutherford, George W. Personal communication. June 9, 1998.

require, MCO involvement in public health education campaigns in their communities without specifically defining the scope or level of such involvement.

The fact that the local public health agencies assumed final responsibility for crafting their MOUs in ways that were both consistent and different from state-level recommendations is also reflective of the relationships between state-level and local-level health departments and the degree of administrative and regulatory oversight that state-level agencies have over local entities. In states where local public health agencies are relatively autonomous units of local government, such as New York, Minnesota, and Michigan, local public health agency officials reported that while they would have preferred to have been involved in the creation of both the Medicaid RFP specifications and the model agreements, they were appreciative of the fact that they were given the latitude to customize their own agreements for local conditions. With the exception of California, where MCOs must send their MOUs to Medi-Cal for review and approval, in the CDC study states, the agreements were not required to be submitted to state-level agencies for review or approval. The New York State Department of Health, among others, offered technical assistance and review "to ensure that the agreements negotiated at the local level are consistent with the State's Public Health Guidelines for Managed Care Organizations."[37]

It is not necessarily surprising that the agreements initially outlined by the state public health officials "devolved" into standard covered service provider agreements during the course of their negotiations with Medicaid managed care organizations. Such instruments are both familiar and accessible to the extent that MCOs are accustomed to their use with their traditional panels of providers such as hospitals and clinical practice groups. Given that the states' "vision" of the public health role of MCOs revolved around service provision and reimbursement issues, the local public health agencies adopted this level of vision in light of the fact that there were no requirements or directives to do otherwise. As one local public health official reported, "We are still in the process of sorting all this out." Thus, the local public health agencies took a conservative course of action that avoided the appearance of imposing duties on MCOs that were not explicitly contained in their contractual relationship with the state Medicaid agencies.

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[37] Letter to the Albany County Health Department from Ellen J. Anderson, NYSDOH Office of Managed Care, August 14, 1996.

2. The MOU as Catalyst

A key question addressed by the study was: "Did requiring or encouraging MOUs between MCOs and local public health agencies lead to the establishment of working relationships?" The answer to this question is "yes"; the MOU process seems to have resulted either in the actual establishment of a working relationship or negotiations to develop such a relationship. In those states that included collaboration requirements and/or recommendations in their Medicaid managed care RFPs and contracts, the basic goal of building a formal relationship seems to have been realized. As one Michigan health official stated, "Local health departments have told us in Southeast Michigan where the RFP was issued that they have had more contact with HMOs in their area in the last few months than they might have had in all the previous decade."

Interviewees in New York also reported that the Medicaid agency informed MCO bidders that if they wanted the Medicaid RFP award for Onondaga County, they would have to sign the MOU. This position on the part of the Medicaid agency led to MCO contact with the public health agency.

3. The MOU Development Process

The most common approach used among the sites we visited represented a "top-down" approach to the creation of MOUs. In several sites, as noted, the state health and/or Medicaid agencies developed model agreements and coordination matrices and templates that they disseminated to local health departments for their use with MCOs in their markets. These templates were generally developed not so much with public health surveillance considerations in mind, but more with the intent of negotiating provider participation agreements. Thus, the focus shifted away from public health-oriented goals of the MOU (i.e., to get managed care to link to the community), and back toward traditional provider network contracts (coverage, network, payments, etc.)[38]

Local public health agency and MCO officials in Minnesota and Michigan reported being excluded from the development of the MOU process as state officials defined their scope and

contents. Local officials viewed this as a shortcoming of the process. They believed that they could have contributed valuable insights that would have saved the state time and money, as well as resulting in MOUs more reflective of, and adaptable to, their local circumstances. In the case of Hennepin County, local governments have seized far more control of the entire Medicaid managed care purchasing process than was the case in other study sites. Hennepin County's response to an attempt by the state to allow an MCO to operate in the county that the county did not want (it considered its market to be saturated at that point) was to join with six neighboring counties to lobby for county-based purchasing of Medicaid. Where the county government is itself the purchaser of managed care, it can be expected that the county's health agency will play a far larger role in determining the extent of its formal relationships with plans that seek to do business in the county.

Michigan's Medicaid RFP process strongly encourages, rather than mandates, local public health agency/MCO collaborations. The state created a coordination template and model MOU for local public health agencies to use in their negotiations with MCOs. This template stressed both personal health services as well as broader public health-related matters (the template is found in the Appendix). Detroit health agency officials rejected this template, however, in favor of a more traditional provider network agreement that dealt squarely with the health agency's needs as a provider of personal health services. In their view, the state's template inadequately addressed the issues that arise for local public health agencies as personal health and medical care providers and thus they rejected the template in its entirety in favor of a more traditional service agreement.

Interviews with local public health agency and MCO officials in Detroit likely best captured the deep concerns voiced in other similar jurisdictions about the future of Medicaid managed care. DHD, with its long history of serving great numbers of people with complex medical needs, strongly believed that it was not in a position to abandon its role as a personal health care provider and viewed the potential loss of Medicaid patients and revenues to MCOs as a major threat to the continued viability of its programs. The health department staff also expressed concerns that MCOs would prove to be unstable players in the Medicaid market and

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[38] Rosenbaum S, Silver K, Wehr E. *Principal Findings From an Analysis of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Programs. op.cit.*

would leave when the care was no longer profitable. MCO officials expressed appreciation for the health department's willingness to negotiate with them while at the same time voicing concern over the rates that the health department expected the companies to pay for covered services. The result at the time of the site visit was an uneasy alliance between public health and managed care as each takes a "wait and see" posture while watching to see if promises on both sides are fulfilled.

4. The MOU Negotiation Process

With the exception of providing some technical assistance, the state agencies for the most part left the MOU negotiation process to the local health agencies, just as would be the case with any provider service agreement. Indeed, this "hands off" policy was consistent with the thrust of the state agency efforts to foster the development of working public health agency relationships in the managed care context. Since contract negotiation lies at the heart of the relationship among the various entities that participate in managed care, learning to negotiate the contract autonomously is central to the managed care integration process. Because entry into the managed care market by public health was the principal goal of the MOU process, public health considerations declined in importance (and as indicated in the Detroit example) were intentionally pushed aside, in favor of getting a basic provider agreement, although vestiges of public health concerns remained.

The Onondaga County "Partnership Agreements" were among the most tightly defined and comprehensively written examples of MOUs in our study. A significant factor in the county's progress in developing collaborative relationships and negotiating MOUs with MCOs has been the County Health Commissioner's proactive stance as both a catalyst and ongoing active leader in this process. This work was accomplished largely by networking as many stakeholders as possible in their development, including health department staff, other county officials, and MCO officials. As a former state-level Health Department official, he had extensive contacts with Albany officials, as well as specialized knowledge of the MOU process from the statewide perspective.

Sacramento County offered a unique example of the application of classic market principles to the MOU negotiation process. Increasingly, using the "safe harbor" provisions

created by federal regulators as a means of exempting certain conduct from potential antitrust prohibitions, health care providers are forming competitor networks that negotiate on behalf of each member of the network in order to increase their collective market leverage with MCOs.[39] Using the notion of a bargaining agent, the Sacramento County health department employed an MOU "broker" to negotiate a standard, acceptable MOU with the six MCOs doing business in the county. The process was given high marks by the MCO officials who were interviewed because of managed care's dependence on standardization to the maximum degree possible, the relative efficiency of the system which the health agency employed, and the impartiality and negotiation skills of the individual elected to represent the health department in its negotiations.

[39] In the absence of such an independent network, the collective negotiation process would be viewed as a *per se* illegal horizontal restraint of trade. *Law and the American Health Care System,* Ch. 2K. *op.cit.*

5. Potential Effects of MOUs on Specific Aspects of Communicable Disease Programs

While it is too early to know how MOUs affect public health agency operations, in their structure and design, the documents (and the processes by which they are created, negotiated, and implemented), hold significant implications for communicable disease prevention and treatment services offered by local health agencies. The effects of the MOUs may be felt in public health agency revenues, the flow of information to and from health agencies, and the standards of care that health agencies use to treat communicable disease.

As noted in Part 3, the MOUs are relatively uniform in their inclusion of personal health services related to the prevention, assessment and treatment of communicable disease. As Table 1 indicates, the MOUs in all study sites addressed immunizations, tuberculosis-related services, some level of services for the prevention and treatment of STDs; all of the CDC sites except Detroit addressed HIV-related services to at least some extent in their documents. As noted, while the documents are similar in the classes of services they cover, they may vary significantly with respect to the precise manner in which the public health agency is expected to interact with plan members and in the scope of the health agency's duties in any particular service area.

In the following discussion, findings related to the four disease program areas are addressed first, followed by an analysis of the cross-cutting variables in the study (financial reimbursement issues, reporting and information flow, and the use of standards of care).

STD Prevention and Control: STD prevention, treatment, and control were subject to extensive variation and debate. The greater variation in STD service arrangements reflects by and large the unresolved issue of confidentiality, as well as a general lack of agreement on how to operationalize shared responsibility between those activities related to individual care and treatment and activities designed to protect public health. The confidentiality issue made STD services a prime example of contractual benefits which MCOs are obligated to furnish but which frequently may be furnished free of charge to MCO members. For example, the Onondaga County MOU specifically provided that STD treatment would be available without charge to MCO members in order to permit the local health agency to continue ensuring that individuals who used the county for care would experience no breach of confidentiality in either testing and

treatment. Other health agency officials indicated that although their MOUs permit them to bill for STD services, in fact they do not do so because of unresolved confidentiality concerns.[40]

This tension between billing and public health concerns around testing and treatment presented one of the clearest examples of how theory and practice diverge. Reasons given by local public health agencies for the failure to bill MCOs included not only the issue of confidentiality but also the high administrative costs associated with billing arrangements, the relatively low numbers of Medicaid-eligible STD clients to begin with, and the availability of sufficient other revenues to mitigate the loss of Medicaid funding.

There was one area of agreement with respect to STDs: that only public health agencies have the expertise, authority, and power to conduct individual partner notification activities and to gather the necessary data for community-wide STD surveillance. However, by and large the MOUs did not obligate the MCOs to ensure that the necessary information to permit partner notification or support surveillance would be forthcoming.

Tuberculosis Prevention and Control: The site studies suggest that MCOs may be particularly willing to delegate the provision of directly observed therapy to public health departments, primarily because they lack the workers and expertise in this particular area of health care. However, MCOs did not appear to be willing to delegate to health agencies their decision-making authority over the extent of medical care that would be covered for a particular patient; neither the MOUs nor the interaction between the company and the health department indicated the transfer of medical necessity decision making powers by the company to the local health department. However, in Onondaga County, where the local public health agency retains the power to make medical necessity determinations for TB treatment, MCO officials generally felt that they should have a greater role in making such determinations, such as the length of hospitalization for individuals with active tuberculosis due of the cost of treatment. In the other study sites, given that the MOUs left MCOs with final decision-making authority over the medical

[40] In fact, such concerns probably are not insurmountable and could be addressed in a variety of ways. It may be that the availability of subsidized care without reimbursement has acted as an inhibitor to a resolution. Furthermore it is unclear whether in light of the high importance of the service, STD prevention and treatment activities should simply continue to be directly financed in order to avoid any diminution in access to care or willingness to use services. For a study that produced similar findings see: Rosenbaum S, et. al. Beyond the freedom to choose: Medicaid managed care and family planning. *J Health Polit Policy Law.* 1997;22(5):1202-1224.

necessity of in-plan provision of diagnostic and treatment services, it was therefore possible under the agreements and in practice for an MCO to order the discharge of an individual whose condition might not have been considered adequately under control by the public health agency. Were such a result to occur, a public health agency could be left with significant financial exposure unless the Medicaid agency were to intervene and overrule the MCO's treatment decision (an option that some, but not all, Medicaid agencies – and possibly other purchasers as well – may reserve under their contracts).

Prevention of Transmission of HIV: An area of significant agreement was prevention of vertical transmission of HIV. MCO interviewees all reported that they disseminate a standard of care that promotes voluntary counseling and testing of all pregnant women for HIV infection. However, there was general agreement that for those women who test HIV-seropositive, referrals to systems of care and case management that are primarily publicly sponsored were most appropriate. Despite this consensus, the MCOs nonetheless reserved the power to make medical necessity determinations under their contracts with local health agencies, just as with tuberculosis. In most cases, the women's assigned primary care providers (if other than the local health agency) would assume a consultative role in the provision of treatment, with pregnancy management carried out by the local health agency. As Table 1 indicates, HIV treatment was not part of the MOU in Detroit. In this city, local health agency officials elected not to include HIV prevention services in their proposed covered service provider agreements with MCOs, since they believed that the city's existing specialty care systems for infected women were adequate. (As a side-note, it was not clear, however, whether all such specialty programs were members of all MCO networks, thereby ensuring access to such specialists by MCO members on an in-plan basis).

Childhood Immunizations: Immunizations are a covered service in all Medicaid managed care agreements. Moreover, the service is one that is more likely to be available through the primary care providers to whom enrollees are assigned. Thus, health agency officials report that while they continue to maintain involvement in the provision of childhood immunizations, some have reduced the number of clinics they offer. Others instituted fee schedules for "out-of-plan" users in order to discourage what they perceived to be the "dumping" of immunization patients onto local health agency facilities. MCO officials reported being interested in collaborating on local outreach efforts with public health agencies in their service areas and saw a

significant public relations value in addressing maternal and child health issues, as well as the opportunity to make a broad impact on the health and well-being of great numbers of people.

Reimbursement for Services Covered by the MOU: Table 3 summarizes the MOU reimbursement mechanisms. Typically the agreements used Medicaid fee-for-service rates in the case of Medicaid-sponsored enrollees. Additionally, the MOUs provided that certain services covered by the MOUs, such as STD and HIV testing services would be reimbursed without prior authorization. Nonetheless, public health officials in Detroit, Sacramento, Hennepin, Onondaga, and Riverside Counties reported that despite the availability of reimbursement, they would probably refrain from billing because of confidentiality concerns, as well as their belief that the volume of reimbursable business would not be sufficient to justify the creation and maintenance of a billing system. Onondaga County officials did in fact develop a TB case rate for disease management of $2,250 for one year of treatment per patient. The level of this charge was determined by the Onondaga County Health Department following analysis of their costs for providing these services. The case rate is paid in annually so as to avoid having to generate multiple billings to the MCOs for individual services. Several MCO officials in the area reported that they considered the charge too high.

Table 3: Billing Mechanisms for Services by Locality as of June 1997

Locality	STD Testing and Treatment	HIV Counseling and Testing	Tuberculosis Screening and Treatment	Immunizations
Onondaga Co., NY	Not billed to MCO or Medicaid; enrollees not charged for services	Billed to Medicaid at FFS rate	DOT for 36 weeks billed to Medicaid; other clinical services (initial evaluation, medications, lab tests, and clinic follow-up visits) billed to MCO at $2,250 for one year of treatment.	Billed to MCO when prior authorization obtained or when child not age-appropriately immunized ($30/visit + $5.00 each additional vaccine preparation)
Detroit, MI	Billed to MCO	(Not mentioned in agreement)	Billed to MCO	Billed to MCO at $12.00 per immunization
Sacramento Co.. CA	Billed to MCO	Billed to MCO	MCO billed only for cost of medications used in DOT provided by local public health agency	Billed to MCO
Riverside Co., CA	Billed to MCO	Billed to MCO	DOT billed to Medi-Cal; other services billed to MCO	Billed to MCO

Despite the fact that local health officials themselves acknowledged not billing MCOs for certain services because of administrative burdens and confidentiality considerations, they also expressed their concerns over cost shifting from the MCOs to the local public health agencies.

Indeed, cost shifting issues were raised by both MCO and local public health agency officials, and the problem surfaced in two ways. First, public health officials cited the loss of direct Medicaid revenues from the state as threatening their ability to finance the provision of care for the uninsured. One Detroit health official stated that even though these Medicaid revenues did not completely cover the health department's costs, the financing nonetheless helped defray the cost of uncompensated care. Public health officials in general held strong beliefs about the potential financial impact of Medicaid managed care on local health agency operations, even as they also indicated their reluctance or unwillingness to establish complex billing arrangements or pursue revenues that might compromise confidentiality.

The second way the issue of cost-shifting surfaced was that, even as local public health agency officials were voicing concerns over the combined effects of declining Medicaid revenues and increased out-of-plan costs as MCO enrollees continued to seek care from them, MCOs cited Medicaid revenue shortfalls as a major problem, along with increased cost-shifting onto their commercial sponsors (where such sponsors existed) as a means of subsidizing their Medicaid losses. This problem was particularly evident in Detroit, where a major MCO with both commercial contracts and a Medicaid managed care contract feared losing its competitive edge to a low-cost MCO that did not participate in the Medicaid market at all and could thus afford to offer the Medicaid agency heavily discounted rates at market entry, as well as reduced rates to other purchasers. The MCO with both books of business believed that cost-shifting losses from its Medicaid business to its commercial clients forced it to raise commercial rates in such a way that its customers would potentially take their business to the low-cost MCO. This was also evident in Onondaga County where MCOs decided to cut their losses and either cease participation in Medicaid managed care or cap enrollment.

Reporting and Data: Because access to data is essential to the ability of public health agencies to carry out core public health functions, the site studies asked specifically about data. Table 4 presents an overview of selected reporting activities between the MCOs and the local public health agencies in the study sites. As the table indicates, there is extreme variation by site and by condition in the approaches taken. For example, several sites are covered by public health statutes that require MCOs and their provider networks to report tuberculosis cases to public

health agencies. No similarly uniform approach exists in the case of STDs or vaccine preventable diseases, however.

Table 4: Reporting Requirements by Locality as of June 1997

Locality	STD Testing and Treatment	HIV Counseling and Testing *	Tuberculosis Screening and Treatment	Immunizations
Onondaga Co., NY	MCO reports patients with STDs to local public health agency on form DOH-389	HIV+ enrollees referred to local public health agency for case management, otherwise no exchange of info about enrollee testing	All confirmed TB cases referred to local public health agency for treatment	Exchange of immunization records between MCO and local public health agency with patient consent
Detroit, MI	MCO "and its provider panel are required to report communicable diseases and certain other conditions to DHD […] mandated by P.A. 368 of the Public Acts of 1978."	MCO "and its provider panel are required to report communicable diseases and certain other conditions to DHD […] mandated by P.A. 368 of the Public Acts of 1978."	MCO "and its provider panel are required to report communicable diseases and certain other conditions to DHD […] mandated by P.A. 368 of the Public Acts of 1978."	DHD reports immunizations it provides for the statewide Immunization Registry; MCOs to report to DHD progress in achieving 90% immunization coverage for enrollees
Sacramento Co., CA	MCO reports STDs to local public health agency, which in turn reports provision of STD services to primary care provider with patient consent	MCO ensures that its providers "follow current disease reporting requirements.," and it is to "participate in and provide data, such as names and addresses of HIV positive members, relative to the development of a comprehensive plan for HIV services in Sacramento County."	MCO ensures that its providers, including its contracted laboratories, comply with requirements to file California Tuberculosis Suspect Case Report forms. MCO informs County of plan disenrollees with active TB	Exchange of immunization records between MCO and local public health agency with patient consent; MCO is to participate in regional immunization registry and "assist county in educating plan providers (including medical laboratories affiliated with the plan) about their responsibilities to report vaccine-preventable diseases."
Riverside Co., CA	MCO will "comply with all Federal, state, and local public health regulations, including the reporting of specific diseases and conditions." Local public health agency will provide medical records to MCO with patient consent.	Individuals who test HIV positive at local public health agency facilities will be referred back to MCO primary care provider for care.	MCO required to refer all active or potentially active TB cases to local public health agencies for services. Local public health agency submits treatment plan to MCO clinical services provider with monthly updates.	Local public health agency administers needed pediatric vaccines and refers members back to MCO primary care provider for subsequent immunizations. MCO informs providers of required standards and need for completing the California Immunization Record.

* Note that Michigan requires named reporting of HIV-infected individuals to the state health department. At the time of this writing, New York and California required reporting of individuals with AIDS diagnoses, but not those with HIV infection who have not progressed to AIDS, although the issue is currently one of wide debate in both states.

In certain situations (such as HIV) the policy regarding the reporting of positive cases varies by state and is unsettled generally. There is thus no reason to believe that MCO agreements with local health agencies would have resolved the matter. In other cases, however, particularly with respect to reporting around STDs, there appeared to be wide variation despite the general consensus regarding the obligation and to report these conditions. Of particular concern is the absence of provisions in the MOUs relating to health agency access to the results of MCO laboratory tests or empirical diagnoses in the area of STDs. Many health agencies traditionally have relied on public health laboratories rather than individual clinicians for

information on persons diagnosed with STDs. As MCOs alter traditional laboratory service patterns and contract with private and/or out-of-state laboratories for services, a critical source of information may be lost. However, this issue by and large was unaddressed either in the documents or in practice.

Standards of Care and Coverage Decisionmaking: Because the templates and the MOUs were drafted by health agencies, they frequently incorporated established public health standards (such as those maintained by the CDC, the American Thoracic Society, the American Academy of Pediatrics, and the Advisory Committee on Immunization Practices) as a means of defining general coverage rules. While the MOUs gathered for the CDC study were by and large not in operation, MCO officials indicated that they had no objection to use of such "macro-allocation" standards. At the same time, it is critical to underscore that on a near-uniform basis, the MOUs did not delegate to the health department the power to make a "micro-allocation" decision (i.e., the power to determine coverage for any particular individual), thereby entitling the patient to treatment. Adherence to pre-established scientific guidelines represents one important aspect of defining what constitutes appropriate medical care. However, the second and crucial phase is deciding whether care will be covered for a specific patient in a specific case. This issue was left to the MCOs: indeed, it was clear from our interviews that local public health officials did not fully appreciate the distinction between "macro-allocation" (which standards will generally guide a decisionmaker) and "micro-allocation" (whether coverage will in fact be permitted for any particular individual.) A unique exception was the Onondaga County Health Department which retains the power to determine which TB patients need DOT services and when hospitalization for TB patients may be indicated. MCO officials were generally very aware of the distinction between macro- and micro-allocation, given their expertise in the use of practice guidelines and standards for utilization review and service authorization purposes.

MCOs reported that they are quite often involved in the dissemination of standards of care to their contracted providers, and they work in tandem with state and local health agencies to obtain this information. One Michigan MCO official characterized his company's non-directive policy on standards of care as, "We have providers who are performing medical care in the tradition of variation which typifies American medical care, without any sort of reduction in variation through an initiative instituted by the health plan. It is standard medical care as it exists

in the community." This "hands-off" attitude is responsive to physicians' desires for clinical autonomy of judgment as well as avoidance of the appearance of the practice of corporate medicine.

V. CONCLUSIONS

The findings from this study support several important conclusions, each of which will be discussed in turn.

A. The MOU Process is an Important One That Should be Promoted, Closely Monitored, and Measured

This study represents an initial effort to examine the MOU process closely as well as the unfolding relationship between local public health agencies and managed care organizations. MOU implementation can be expected to be as complex as negotiation of the agreement itself. Because the CDC-sponsored site visits occurred during an early stage of MOU process, the issues that arise in implementation were only beginning to be visible. The second round of site visits that occurred under the Kaiser Foundation-sponsored portion of this project may shed greater light on these issues.[41] Moreover, this study did not attempt to quantitatively assess measurable clinical outcomes of diseases that may have occurred as a effect of implementing MOUs. Thus, the question of whether the presence of an MOU is associated with greater levels of preventive health care utilization or better management of communicable disease, as measured by accepted access, utilization and effectiveness of care measures, cannot be answered here. Greater amounts of time and more rigorous data collection would be necessary, as would the fashioning of a study baseline against which to compare post-MOU performance.

Despite these limitations, this study permits important qualitative findings about the use of MOUs in shaping communicable disease prevention and treatment programs in a managed care era. One of the most significant is that as noted, the MOU was a spur for collaboration. A second is that the fact of the MOU's existence creates a starting point for analyzing the effects of formal versus informal collaboration between MCOs and local public health agencies. The third is

[41] The results of the Kaiser-sponsored site visits will be provided to the CDC immediately upon completion of the final report.

that the process is widespread and replicable although the nature of the replication can be expected to vary as local conditions change.

The Strengths of the MOU Process: With the exception of Minnesota, the requirements for MCOs and local public health agencies to enter into collaborations and develop MOUs or similar agreements serve the important purpose of bringing these two domains together to discuss their mutual and discrete responsibilities. The MOUs represent a tangible legal instrument around which the local public health agencies and MCOs could conduct their negotiations. The templates from which they were developed reflect the positions of state health and Medicaid with respect to how they envision the overlap in responsibility and duty and allow for a structured negotiation regarding how these duties will be carried out.

MOUs are in Early Development: The MOUs we examined were "first-generation" and represented an initial attempt to address shared responsibilities. Because these MOUs represent an initial effort to resolve issues of great moment for the health care system in the transition to managed care, it is probably not surprising that the MOUs emphasize how public health agencies will adapt to managed care far more than they address the extent to which MCOs will transition to a community-wide vision of responsibility. This limitation of the current generation of MOUs – that is, their failure to address issues of MCO relationships to public health imperatives – is probably consistent with the realities of managed care, as well as the underlying dynamics of the managed care transformation. Managed care in Medicaid has been pursued in many states with breathtaking speed and policy urgency. Anecdotal evidence suggests that in the first wave, the agencies, programs and providers that are affected by the transformation believe that the accommodation duty lies with them and that it is they who must adopt to a new world. Only at a later point in the evolution of markets do governments and society begin to consider the ways in which the market will have to change to accommodate broader social goals. Thus, the limited nature of the MOUs (that is, their failure to address the broader public policy issues that arise as managed care begins to integrate into the larger community) should not be seen as a permanent constraint on the public health/managed care partnership, but instead, as a product of the evolutionary manner in which markets change and governments in turn respond to a changing market.

Importance of Effective MOU Negotiations: Our research suggests important findings regarding the negotiation of MOUs. Negotiations appeared to be simpler and more expedient with MCOs that were small "home-grown" firms, especially those which are organized as Medicaid-only MCOs (and which may in fact be captives of the very public entities to whom public health agencies also answer, such as a county government). These MCOs brought to the table a greater awareness of the health and social support needs of the Medicaid population, particularly when they had previous experience with voluntary Medicaid managed care enrollment. As instrumentalities of local government, captive MCOs also may have a *de facto*, if not legal, duty to reach accommodation with a public health agency in their service area.

Despite the promising nature of the MOU process, there are clearly problems that suggest the need for harder bargaining techniques or the replacement of lost funds with other supplemental financing sources. Local public health agencies that wished to continue offering a spectrum of personal health services to the uninsured as well as Medicaid patients using services on an out-of-plan basis often found themselves in conflict with their need to finance these services and states' policy directives to mainstream Medicaid beneficiaries into managed care. As enrollees shifted into managed care plans, access to patients and revenues was affected, with significant financial consequences reported by health agencies. The impact appeared to be felt among health agencies with strong personal care missions and obligations toward high numbers of uninsured patients, such as the Detroit health department.

We also found that when public health agencies invest in efforts to educate MCOs about the importance of certain public health imperatives, negotiation may be easier. When MCOs are able to grasp their members' (and their own) stake in healthy communities, even if achieving a healthy community involves the assumption of duties that go beyond the traditional limits of insurance, negotiations may be easier. The MOU process is of crucial importance to this educational imperative, since it provides a means of initially communicating about how the public health agency will work with the MCO to meet its own contractual needs. Building on this base, public health agencies and MCOs may at a later point begin to negotiate around the role of managed care in meeting community-wide public health needs. This remains to be seen, however.

Limits of the MOU Process: The MOU process has serious limits, as well. Because implementation is only beginning, the enforceability of the agreements is unclear, as are the effects

of the agreements on the financial operations of public health agencies and the MCOs. It is also clear that in only two study sites – Sacramento and Onondaga County – did the public health agency borrow market techniques to create a better bargaining climate. In Sacramento the health agency developed a messenger model intermediary to effectively negotiate with several MCOs. In Onondaga County the commissioner was able to use his considerable influence to persuade the ultimate purchaser (in this case, the Medicaid agency) to bar market entry to MCOs that did not do business with the public health agency. Achieving market power either through collective action or through regulation of market entry, are specific techniques that local public health agencies must learn to use, along with learning to understand the policy content of the MOU.

B. Despite Its Importance, the MOU Process Cannot Be Expected to Resolve Major Policy Matters that Transcend Specific Provider Agreements

Even where the MOU process works well, this study suggests that it will not be effective by itself in resolving crucial policy issues that go to the heart of public health functioning in a managed care era. Provider contracts can carry out and conform to broader public policy: they cannot make it. Major issues such as confidentiality of patient information, cross-subsidization of MCO operations by local public health agencies furnishing out-of-plan care, access by public health to surveillance and treatment data essential to community health monitoring, and the role of public health agencies not only in general care standard-setting but also, actual medical treatment decision-making for conditions that affect the public's health, are all policy issues of enormous moment. They must be resolved by purchasers in consultation with state health agencies. It is in these areas that the policy-making aspect of public health practice, as captured in the 1988 Institute of Medicine study, *The Future of Public Health*, is at its most crucial. Earlier studies of contracts between managed care organizations and Medicaid agencies suggest that these issues are unresolved at the present time. This lack of resolution shows up in the provider agreements, as well.

Thus, as important as the MOU process may be in fostering the integration of certain public health agency activities into managed care, its role in the integration of managed care into public health domains is minimal at this point. As noted, these limitations are not surprising given the urgency of addressing the survival of key public health agency functions in the first wave of

managed care/public health collaboration. For example, one of California's primary objectives for promulgating the use of MOUs between MCOs and local public health agencies was to link public health into managed care operations in order to assure continued access by public health to revenue streams for the services they continue to provide.[42] Now that the process is underway, it is incumbent to build and strengthen it and to return to the major policy questions that the MOU process alone cannot be expected to resolve, even when such a process is mandated by the purchaser.

The findings from this study suggest that state Medicaid and health agencies are willing to require the development of a formal relationship between MCOs and local public health agencies. This level of commitment must now be carried back to the deeper policy backdrop against which MOUs are developed and negotiated. Questions such as those that go to core public health functioning in an age of managed care, such as the authority of public health agencies to make individual coverage determinations in the case of enrollees with highly communicable diseases, are properly dealt with in state law or regulation of general applicability;[43] they also can be addressed through the contracts that individual state purchasers (as well as private purchasers) negotiate with MCOs. California's experience, again, is relevant to this point. Officials there believed that certain public health imperatives and duties, such as responsibility for reporting of notifiable diseases and medical necessity determinations, are of such fundamental importance that they should not be left to the vagaries of the marketplace; rather, they are better addressed in state statutes and regulations, thereby achieving consistency across all markets in the state. The MOUs thus are instruments that augment and fill in operational gaps without superseding public health duties as already codified in state law.[44]

In fact, there is reason to anticipate that interest in this type of community-wide restructuring of managed care will grow on both sides. MCOs have an interest in supporting

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[42] Rutherford, George W. Personal communication, June 9, 1998. Dr. Rutherford noted that while the MOU process leaves a great deal to local practices and preferences, fundamental policy matters such as the role of public health agencies in making binding coverage and treatment determinations for members with tuberculosis are addressed in state rules of general applicability, not individual MOUs.

[43] While the Employee Retirement Income Security Act (ERISA) places constraints on the extent to which states can regulate employee benefit plans, in recent years courts have begun to distinguish between the regulation of managed care organizations and regulation of employee health benefit plan administration. See, e.g., *American Drug Stores v. Harvard Pilgrim Health Care, Inc.,* 973 F. Supp. 60 (D. MA 1997).

[44] Rutherford, George W. Personal communication, June 9, 1998.

public health functions of population-based disease control and surveillance. Rational risk adjustment estimates and market entry strategies depend on having reliable health status information about the communities in which MCOs operate or are considering entry. Thus, MCOs have a potential vested interest in supporting well-managed and financially solvent public health departments in that these departments are charged with collecting and analyzing population-level health statistics. The availability of accurate and timely statistics reflective of a community's prevalence and incidence of acute and chronic disease conditions is, or should be, a vital component in the decision-making process of what services an MCO can offer (and at what prices). This is clearly an area where both MCOs and local public health agencies can collaborate in making the case to state legislatures for adequate funding for the conduct of local population-based public health assessment and surveillance activities.

VI. RECOMMENDATIONS

We recommend several different activities on the part of the CDC. First, we recommend that CDC actively encourage Medicaid agencies as well as other public and private purchasers to require or actively encourage the use of an MOU process. The MOU system creates a structure for integrating public health into managed care and helps educate both sides about the needs of the other. The MOU process is of fundamental importance as an evolutionary step toward bringing together the worlds of public health and managed care. While this study focuses on Medicaid-based MOUs, nothing about the process is limited to publicly financed health care. Indeed, any follow-up effort should be structured to bridge both public and private purchasers.

Second, we recommend an investment in training state and local public health agencies in the structure and content of MOUs as well as in the MOU bargaining process. Several state and local health agencies have evidenced major leadership in this regard. The CDC should implement an initiative in this area that is designed to provide broad public education about MOUs and provide support and technical assistance at both the state and local level of public health. Public health agencies at both the state and local levels should be trained in drafting and negotiating contracts. The MOUs we examined were especially vague in the areas of contract duties and rights, monitoring and compliance, and remedies in the event of breach of one or more terms by either party to the contracts. Moreover, agencies should receive assistance not only in structuring

and drafting the agreements, but also in the development of techniques for strengthening the bargaining position of local health agencies, much like the managed care networks that have grown in the private sector. Indeed, on many of these issues, important alliances can be created among local public health agencies, and other providers with community-wide responsibilities such as health centers. Many health centers already have formed fledgling provider networks which could serve as examples for public health agencies.

Third, we believe that the MOUs, even if in wide and active use, will continue to leave unaddressed certain broad public health matters that concern how managed care relates to public health. These are matters that deserve the highest level of state policy attention, not only for Medicaid agencies, but for all public and private purchasers of managed care. CDC is positioned to play a major leadership role in this regard through continuing education, dissemination of sample purchasing specifications, the development of model legislation relating to the reporting of public health data and participation in public health activities, and meetings and conferences on opportunities and challenges for public health in managed care, and other techniques. This educational, technical assistance, policy analysis, and support role should be viewed as multi-year and multi-faceted.

Furthermore, we believe that the "cross-cultural" nature of interactions between public health, Medicaid and managed care has to be acknowledged and addressed. Training is needed at all levels and in all sectors in the mission and operations of other sectors. This training needs to emphasize both what is common in mission and operations and what is extremely likely to vary. In addition, on a day-to-day level, participants in cross-sector interactions need to recognize that they have a responsibility to provide orientation to their counterparts on the specifics of their circumstances. If credible and objective facts are not available, perceptions, well-founded or not, will prevail.

Finally, given the social stigma of diseases such as STDs and HIV, state health and Medicaid agencies need to consider better ways to accommodate the need for public provision of these services and their financing. Services that are essential to the protection of public health and control of the spread of communicable disease cannot be left to the whims of the market. Gaining a strong, nationwide foothold for market relationships is an important goal, but in the interim, access to vital public health services could be lost. Alternative approaches include continued and

expanded direct funding to local public health agencies specifically for these purposes, as well as the development of new billing mechanisms that are responsive to both public health and MCO reporting requirements.

Appendix

The 500-page appendix materials for this report are too large to include in the Adobe .pdf version of this report. To receive a copy of the Appendix, please contact D. Richard Mauery, MPH at (202) 530-2376 or e-mail ihodrm@gwumc.edu. ***You may also write to him at The Center for Health Policy Research, 2021 K Street NW, Suite 800, Washington, D.C. 20006.***

List of Documents

1. **CDC Study Sites Interview Protocols**
2. **Minnesota:**
    - 2.1. Collaboration Plan Legislation – 62Q.075 Local public accountability and collaboration plan.
    - 2.2. Collaboration Plan Sample Forms
3. **New York:**
    - 3.1. Public Health - Managed Care Partnership Agreement Between Onondaga County Health Department and Managed Care Plan
4. **Michigan:**
    - 4.1. Coordination and Collaboration Between Health Plans and Public Health Agencies on Selected Services
    - 4.2. Model Agreement Between HEALTH PLAN and Local Health Department (LHDs)
    - 4.3. Detroit Health Department Model Fee for Services Agreement with Qualified Health Plans
5. **California:**
    - 5.1. Medi-Cal Managed Care Request for Application: Sample Suggestions for Subcontract Between a Medi-Cal Managed Care Contractor and Local Health Department (LHD)
    - 5.2. Sacramento County: Draft Medi-Cal Managed Care Agreement
    - 5.3. Riverside County: Agreement Between Molina Medical Centers and Riverside County Health Services Agency

6. **Kaiser Study Sites Interview Protocols**
7. **Texas:**
    - 7.1. Harris County: Agreement Between "ALPHA Texas, Inc." and Harris County
8. **Oregon:**
    - 8.1. HMO Medical Services Agreement
9. **Delaware:**
    - 9.1. The Role of Public Health in the Diamond State Health Plan: A Proposal by the Division of Public Health
    - 9.2. Master Agreement Between Delaware Division of Public Health and MCD Health Services Corporation: First State Health Plan
10. **Tennessee:**
    - 10.1. TennCare Provider Agreement Between the Department of Health and Health Net TennCare HMO, Inc.
    - 10.2. Shelby County: Blue Cross and Blue Shield of Tennessee Group Practice Agreement
11. **Ohio:**
    - 11.1. Montgomery County: Participating Provider Agreement