THE ROLE OF LOCAL GOVERNMENTS IN MEDICAID MANAGED CARE: ISSUES AND OPTIONS

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EXECUTIVE SUMMARY

Managed care is changing the relationships among purchasers, providers, and consumers of care throughout the health care system. These changes have unique dimensions in Medicaid managed care, since in many states the traditional Medicaid program involves complex and often little-understood divisions of responsibility among different levels of government. These dimensions must be taken into account as Medicaid managed care is designed and implemented.

The role of local governments in Medicaid managed care varies considerably around the country. According to state Medicaid director responses to a 1998 Mathematica questionnaire, local governments play little or no role in Medicaid managed care in more than one-third of the states, while they play major roles in another third of the states.[a]

The Medicaid directors reported that local governments contract with managed care organizations (MCOs) in 10 states and participate in program design in 11 states; they monitor managed care access and quality in 6 states, and handle administrative functions such as eligibility determination in 14 states and beneficiary enrollment in 10 states; local governments function as MCOs in 11 states; they serve as providers of services in Medicaid managed care programs in 37 states, most commonly through public health departments (25 states), mental health centers (22 states), hospitals (21 states), and clinics (18 states).

As the existing diversity demonstrates, there is no one way states do Medicaid managed care, and no one way to divide responsibilities among state and local governments. Since these program features can affect important underlying state and local concerns, they raise issues and questions that state and local officials should address when designing and implementing Medicaid managed care programs. This report highlights these issues and questions and illustrates them with discussions of how state and local officials in different parts of the country have dealt with them. It concentrates in particular on the implications of Federal Health Care Financing Administration (HCFA) regulatory requirements and on recent changes in the Medicaid managed care marketplace and in the focus of state Medicaid managed care programs.

Reasons for Local Government Involvement in Medicaid Managed Care

There is a wide range of reasons why local government may or should be involved in Medicaid managed care, which includes:

- **Legal.** State law may assign some functions related to Medicaid managed care to local governments, such as Medicaid eligibility determination, or service delivery for functions like mental health, public health, or childhood immunization.

- **Financial.** Local governments provide some portion of Medicaid program funding in more than half the states, and they also often fund local Medicaid providers, such as hospitals, mental health centers, clinics, and public health agencies.

- **Administrative capacity and local expertise.** Local governments and agencies may have especially strong administrative capabilities and experience in beneficiary counseling and

[a] This report applies primarily to risk-based managed care programs, but the questionnaire was not entirely explicit on this point, so some states that operate only non-risk primary care case management (PCCM) programs, such as Arkansas, reported local government involvement in those programs.

enrollment, quality and access monitoring, and developing ties with local providers of Medicaid and social and ancillary services.

- **Manageable scale.** Some states, such as California and New York, are so large in terms of population and/or geographic distance that local administration of Medicaid managed care may be more efficient and effective than state administration.

- **Preservation of traditional "safety net" capabilities.** Local governments may have financial or other ties to the safety net of local public hospitals, clinics, health departments, and mental health centers, which have become dependent on Medicaid revenues to support treatment for the uninsured and other under-funded activities. These providers may be threatened by the advent of Medicaid managed care. The established ties between local governments and safety net providers could facilitate government support for them.

- **Local control and autonomy.** Local governments may believe that state program designers and "outside" MCOs will not be sufficiently responsive to local concerns, and may also shift health care dollars to other parts of the state. Retaining a large degree of local autonomy and control over Medicaid managed care is one way of responding to those concerns.

- **Impact on beneficiaries.** MCOs and providers who are locally accountable may in some cases be more accessible and responsive to Medicaid beneficiaries and their advocates, who are generally not well organized and thus have difficulty influencing state-level officials. Since local governments often fund and/or operate social and non-health services, they may also be in a better position to link Medicaid managed care beneficiaries to local providers.

- **Political considerations.** Local government responsibility for managed care functions may be an appropriate and prudent response to the concerns of local elected officials who may have influence in state-level Medicaid managed care decision making.

Constraints and Competing Concerns

While there are a number of reasons why a state may want to involve counties and other local governments in the design and operation of Medicaid managed care, there are constraints and competing concerns that states also need to address, including:

- **HCFA requirements.** HCFA requires that Medicaid programs be administered by a “single state agency;” conflict-of-interest safeguards be built into the administration of managed care programs; managed care procurements involve open and free competition “to the maximum extent practical;” and managed care beneficiaries be allowed a choice of managed care plans. These requirements put limits on the amount and type of Medicaid managed care responsibility states can delegate to local governments. They may also conflict with local government goals of protecting local responsibilities, providers, and access to Medicaid funding.

- **State administrative coordination and consistency.** Policy and administrative coordination can be especially difficult when separate levels of government with different agendas and priorities are involved, when there may be conflicts of interest between purchaser or administrator and provider roles, and when the decisions require a large measure of discretion and judgment. If MCOs, providers, and beneficiaries are treated differently depending on which local jurisdiction they are in, complaints and the attendant administrative burden may migrate back to the state level, requiring state legislators, governors' offices, and Medicaid agencies to sort out the

conflicts, Consistency in data requirements is a special concern, since both MCOs and administrative and oversight agencies cannot function effectively if the data they must collect, submit, and use vary from one local jurisdiction to another.

- **Administrative capacity of local governments.** Administering a Medicaid managed care program requires experience and skills that are not always available at the state level, and that may be even harder to develop and maintain at local levels. In large measure, the issue is one of scale and resources. Some local governments have larger populations than most states, and have comparable or greater administrative capacity. It is also a question of leadership, commitment, experience, and expertise. There are cases in which these ingredients are present in small local governments, and many where they are not in large state governments. Nonetheless, there are limits on the extent to which these less tangible assets can offset insufficient size and resources.

A Framework For State And Local Decision Making

State and local governments assessing their appropriate roles can learn from the experience of states in which local governments play significant roles in Medicaid managed care programs. However, these decisions are highly context-specific. Just because something seems to work in one state does not mean that it will work elsewhere. Approaches that were unsuccessful in one context may nonetheless be worth trying in another.

The paper includes a check-list of questions that state and local officials can ask to make sure that they have not overlooked any major considerations. How the questions should be answered and how much weight should be given to the various often-competing considerations will have to be determined separately in each state and context.

Emerging Issues

Medicaid managed care is currently evolving in at least two important ways, both of which may significantly impact how states and localities assess the appropriate role of local governments in managed care in the next few years. They are:

- **Potential impact of Medicaid-dominated MCOs.** Commercial MCOs appear to be losing interest in Medicaid, leaving more of the Medicaid business to Medicaid-only or Medicaid-dominated MCOs These Medicaid MCOs are often made up primarily of local hospitals, clinics, health centers, and other "safety net" providers. Local governments may perceive these "home-grown" MCOs as less threatening than outside commercial MCOs. If this trend toward locally based Medicaid MCOs develops in a particular state, it may reduce the concerns about private sector competition and local accountability that have prompted some local governments to seek broader Medicaid managed care responsibilities.

- **Potential linkages with locally funded social and ancillary services.** States are seeking to extend Medicaid managed care to Supplemental Security Income (SSI) and other disabled populations. These individuals are much more dependent on locally funded and provided social and ancillary services than the generally healthy AFDC/TANF and related populations (which were covered in the earlier stages of Medicaid managed care). Involving local governments more extensively in Medicaid managed care could facilitate better links between Medicaid-funded services and these local services. It could also, however, generate even greater conflict over which level of government should be in charge.

Further research and studies of specific state and local experiences are needed in both of these areas.

Conclusion

States and local governments considering their appropriate roles in Medicaid managed care should focus on their resources and goals, and on the context in which they will be operating. While capacity and experience is important in all cases, other constraints and competing concerns will vary with the specific roles that are envisioned for local governments and the goals states and localities aim to achieve For example:

- **Purchaser.** Functioning as a Medicaid managed care purchaser at either the local or state level requires substantial administrative resources, skills, and experience. Conflicts of interest may arise if local government is also a service provider or funder.

- **Administrator.** Performing administrative functions such as eligibility determination, beneficiary counseling, care coordination, and monitoring of access and quality may build on local strengths and experience. Conflicts of interest may arise if the local government is a beneficiary counselor or program monitor and also a Medicaid service provider, but care coordination may be more effective if the local government administers or funds a variety of Medicaid and related services.

- **Provider of services.** Providing Medicaid services or funding service providers may be what prompts local government interest in performing Medicaid managed care purchaser or administrator functions, but performing some of these dual roles may raise significant conflict-of-interest issues.

Local governments that want to assume Medicaid managed care responsibilities because they think doing so will protect them (and local service providers) from private-sector competition should realize that HCFA purchasing and conflict-of-interest regulations may prevent them from reaching that goal. They should also consider whether the threat of private-sector competition is as great now as it appeared to be a year or two ago. States that want to shift Medicaid managed care financial and administrative responsibility to local governments because they believe it may lessen the burden at the state level should realize that divided responsibility brings problems of its own, and that HCFA regulations require that the state remain ultimately accountable.

Those states and localities that want to share responsibilities for Medicaid managed care because doing so would build on local strengths, make Medicaid more responsive to local conditions, and make the program work better for beneficiaries will likely find that there are ways of accomplishing those goals that will comply with federal regulations and result in a Medicaid managed care program that meets the needs of their state and its citizens.

I. INTRODUCTION

Managed care is changing relationships among purchasers, providers, and consumers of care throughout the health care system. There changes have unique dimensions in Medicaid managed care, since in many states the traditional Medicaid program involves complex and often little-understood divisions of responsibility among different levels of government. Counties and other local governments may have financing, administrative, policy making, regulatory, purchaser, provider, and public health responsibilities within or related to state Medicaid programs that may be changed in important ways with the advent of Medicaid managed care. For example:

- Medicaid funding that local public hospitals, community clinics, and public health agencies have used to provide care for the uninsured and other purposes may be less available under managed care.
- Beneficiary enrollment activities performed by local agencies may be taken over by Medicaid enrollment brokers under contract with the state.
- Responsibility for care coordination, case management, and provision of care for high-needs populations previously handled by local agencies may be transferred to managed care organizations (MCOs).
- Previously settled arrangements between state and local entities for the provision of mental health services and childhood immunizations may be unsettled by managed care.
- State efforts to maximize federal Medicaid funding by making special payments to local government providers may not be as feasible under Medicaid managed care.

The Center for Health Care Strategies, which for the last several years has been helping states design and implement Medicaid managed care programs for vulnerable populations, identified the role of counties and other local governments in Medicaid managed care as a key issue in a number of states they visited. The Center commissioned this policy study to help state and local officials better understand their program design options in states where local governments may play a significant role in Medicaid managed care. The emphasis in the study is on helping states that are in the relatively early stages of Medicaid managed care program design, including those that may have extensive experience with managed care for the AFDC/TANF and related populations, but are now considering extending managed care to disabled and elderly SSI populations.[a] The study draws primarily on the experiences of states in which counties have played a significant role in Medicaid managed care.

The study is designed to take into account the wide diversity among state and local governments throughout the country, the very different pre-managed-care arrangements that exist from state to state, and the differences in various states' Medicaid managed care goals. There is no one right way to do Medicaid managed care, and no one right way to divide responsibilities among state and local governments. What works well in one state may not work in another.

There are, however, important issues and questions that state and local officials should address when designing and implementing Medicaid managed care programs. This study highlights these issues and

[a] The Aid to Families with Dependent Children (AFDC) program was replaced on July 1, 1997 by the Temporary Assistance to Needy Families (TANF) program. The AFDC/TANF and related populations are made up primarily of young women and children. Those eligible for Medicaid as a result of the Supplemental Security Income (SSI) program are disabled, elderly, or both.

questions, and illustrates them with discussions of how state and local officials in different parts of the country have dealt with them.

The study is based on:

- A review of relevant literature, state documents, and Web sites
- A February 1998 survey of all state Medicaid directors that provides an inventory of the roles local governments currently play in Medicaid managed care programs in each state
- Discussions with an expert panel of current and former state and local officials and health policy researchers convened in June 1998 by Mathematica Policy Research [a]
- Telephone interviews in 1998 and 1999 with additional state and local officials and researchers

II. WHAT ROLES DO LOCAL GOVERNMENTS CURRENTLY PLAY IN MEDICAID MANAGED CARE?

Mathematica Survey of State Medicaid Directors

In February 1998, Mathematica sent a one-page questionnaire to all state Medicaid directors asking:

> *Do counties or other local governments perform or provide significant funding for any of the following functions in your Medicaid managed care program?*[b]

All 50 states responded. The results are shown in Table 1.

Local governments functioned as providers or funders of Medicaid services more commonly than they functioned as purchasers or administrators. The Medicaid directors reported that local governments provided or funded Medicaid services in 37 of the 50 states. Public health departments were the most common locally supported service providers (25 states), followed by mental health centers (22 states), hospitals (21 states), and clinics (18 states). Local governments functioned as MCOs in 11 states. They performed or funded Medicaid administrative functions such as eligibility determination in 14 states, and beneficiary enrollment in 10 states. Local governments monitored Medicaid managed care access and quality in 6 states. They participated in the design of Medicaid managed care programs in 11 states and contracted with MCOs in 10 states.

States vary substantially in their reliance on local governments in Medicaid managed care programs. Local governments performed five or more of the 11 functions listed on the questionnaire in 14 states (Arizona, California, Colorado, Georgia, Illinois, Indiana, Louisiana, Maryland, Minnesota, New York, Oregon, Pennsylvania, Texas, and Wisconsin), while they reportedly played no role in Medicaid managed care in 10 states (Arkansas, Montana, Nebraska, New Hampshire, New Mexico, Rhode Island, South Dakota, Vermont, Washington, and Wyoming), and only one function in 8 others (Delaware, Hawaii, Idaho, Iowa, Mississippi, Tennessee, Virginia, and West Virginia).

[a] Appendix A lists the expert panel members and their affiliations.

[b] Appendix B contains the cover letter and the questionnaire. This report applies primarily to risk-based managed care programs, but the questionnaire was not entirely explicit on this point, so some states that operate only non-risk primary care case management (PCCM) programs, such as Arkansas, reported local government involvement in those programs.

Local Government Roles	*Total*	AK	AL	AR	AZ	CA	CO	CT	DE	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	MD	MA	ME	MI	MN	MO	MS
Purchaser/Administrator																										
Managed care program design	11				•	•					•			•						•						
Contracting with MCOs	10				•															•						
Eligibility determination	14				•		•				•				•					•				•		
Beneficiary enrollment	10						•							•	•					•			•	•		
Monitoring of access and quality	6																			•				•		
Any of Above	22																									
Provider of Services																										
Managed care organization	11				•	•				•	•			•							•			•		
Hospital	21		•	•	•	•	•			•	•			•	•				•		•			•	•	•
Clinic	18			•	•	•	•	•		•	•		•	•	•				•			•	•	•	•	
Public health department	25		•			•	•	•		•	•			•	•		•	•	•	•		•	•	•	•	
Mental health center	22		•		•	•		•	•					•	•		•	•	•	•	•		•	•		
Other provider	6			• [1]		• [2]						• [3]				• [4]			• [5]							
Any of Above	37																									
Total by individual state		0	3	3	7	7	5	3	1	4	6	1	1	7	6	1	2	2	5	7	3	2	4	8	3	1

III. REASONS FOR LOCAL GOVERNMENT INVOLVEMENT IN MEDICAID MANAGED CARE

There is a wide range of reasons why local governments may or should be involved in Medicaid managed care. This section briefly describes those reasons, with illustrations from states in which local governments have played significant roles in Medicaid managed care. The next section outlines the major constraints and competing considerations that states should take into account as they assess appropriate roles for local governments in Medicaid managed care programs.

Legal

State law may assign to local governments or agencies some functions that are related to Medicaid managed care. Care delivery responsibilities are particularly common. In many states, for example, mental health services are provided or substantially funded by local governments or agencies, such as community mental health centers. Local public health departments often have responsibilities that are closely related to Medicaid: primary care services, such as providing childhood immunizations and other health care monitoring; and eligibility determination and enrollment of Medicaid beneficiaries.

These formal allocations of responsibility to local entities generally reflect political and policy judgments. Those judgments may have been reached at a different time and in a different context, and the advent of Medicaid managed care may provide an occasion to review their appropriateness. If the local entities want to maintain these responsibilities, however, Medicaid managed care designers typically will need to recognize and accommodate these preferences in some fashion.

In Oregon, for example, counties were responsible under state law for management of the local public mental health system, and all money for public mental health services, including Medicaid, passed through each county.[a] When mental health services were added to Oregon's Medicaid managed care program in 1995, the legislature sought to balance protection for this long-standing county role with a desire to better integrate physical and behavioral health services through managed care. The legislature required an initial demonstration program, in which counties serving about 25 percent of Medicaid managed care eligibles were given a right of first refusal to serve as mental health managed care contractors. When this two-year demonstration showed positive results, the state expanded managed mental health care statewide in 1997, requiring all contractor applicants to participate in a planning process and giving preference to those that proposed to ensure that more than half of beneficiaries would receive services from traditional county providers.[b]

Financial

If local governments provide some portion of the funding for the state Medicaid program, they may have a greater interest in the design and implementation of Medicaid managed care than if they had no direct financial stake. The limited data that are available suggest that there are some links between local financial participation in Medicaid and local government performance of Medicaid managed care functions, but that other factors are also at work.

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[a] Deborah Agus. "County Role Changing as Oregon Takes Mental Health Managed Care Statewide." SAMHSA Managed Care Tracking Report, Vol. 1, No. 1, February 1998. Available on the Web at www.samhsa.gov/mc.

[b] For additional detail, see Jessica Mittler and Marsha Gold. "Managed Care for Low-Income Populations With Special Needs: The Oregon Experience." Prepared for the Henry J. Kaiser Foundation and The Commonwealth Fund, May 1999.

We compared two data sources with the results of the February 1998 Mathematica survey of Medicaid directors:

- The most recent U.S. Census Bureau survey of state and local governments, which reported the local share of "welfare vendor payments" (85 to 90 percent of which are payments to Medicaid service providers) in 1994-1995

- A 1996 National Association of Counties (NACO) survey of state associations of counties, which reported county participation in states' Medicaid costs, and provided brief summary information on the nature of that participation

The comparison is summarized in Table 2, and the NACO survey is reprinted in Appendix C. There appears from Table 2 as a whole to be no obvious correlation between local funding of Medicaid and local government involvement in Medicaid managed care. Among the 15 states in which the Census Bureau reported that the local share of Medicaid payments was one percent or more, for example, Medicaid directors reported that local governments performed five or more managed care functions in 4 of the states, but none or only one in 5 others. Among the 27 states in which the NACO survey indicated that counties participated in states' Medicaid costs, Medicaid directors reported that counties performed five or more managed care functions in 10 of those states, and none or only one in 7 others.

However, a more detailed look at specific functions does suggest a relationship in some areas:

- **Provider of services.** In those cases in which the NACO survey reported that counties participated in the financing of mental health and mental retardation services, Medicaid directors reported that local providers of these services play a role in Medicaid managed care (Iowa, Kansas, Michigan, Pennsylvania, and Wisconsin).

- **Funder of services.** In cases in which the NACO survey indicated that counties pay a significant portion of the overall Medicaid budget, Medicaid directors reported that local governments play major roles in Medicaid managed care (7 or more functions) in some cases (Arizona, California, and New York), but not in others (New Hampshire, New Mexico, North Carolina, and North Dakota).

- **Eligibility determination. When** the NACO survey indicated that counties fund Medicaid costs related to eligibility determination, Medicaid directors also generally reported that local governments play a role in eligibility determination and beneficiary enrollment (Colorado, Indiana, Minnesota, New Jersey, North Carolina, North Dakota, Ohio, and Virginia), although there are exceptions (Montana).

Even when counties do not directly pay a major portion of Medicaid costs, they may be financially responsible for closely related programs that serve the Medicaid population. In Minnesota, for example, counties are mandated by state statute to provide and finance mental health, substance abuse, and public health programs that serve both Medicaid and non-Medicaid populations. The NACO survey also reports that Minnesota counties pay 100 percent of the non-federal share of Medicaid administrative costs related to client services. Minnesota counties have no financial responsibility for the Medicaid services themselves, however. Minnesota is currently seeking a Medicaid Section 1115 waiver to allow county governments to serve as managed care purchasers in order to better integrate these and other county-ABLE

State	Local Share of Total State Medicaid Payments[a]	Number of Local Functions Performed[b]	County Participation in State Medicaid Costs[c]	State	Local Share of Total State Medicaid Payments	Number of Local Functions Performed	County Participation in State Medicaid Costs
Alabama	0.5%	3		Montana	0%	0	2
Alaska	0	0		Nebraska	0.3	0	
Arizona	19.1	7	2	Nevada	*	3	2
Arkansas	0	3		New Hampshire	0.8	0	2
California	1.1	7	2	New Jersey	1.1	4	2
Colorado	1.1	5	2	New Mexico	2.7	0	2
Connecticut	2.1	3		New York	2.7	8	2
Delaware	0	1		North Carolina	1.2	3	2
Florida	0.1	4	2	North Dakota	1.1	2	2
Georgia	0	6		Ohio	2.7	2	2
Hawaii	0	1		Oklahoma	0	4	
Idaho	4.1	1		Oregon	0.1	6	2
Illinois	0.2	7		Pennsylvania	*	7	2
Indiana	0.9	6	2	Rhode Island	*	0	
Iowa	2.2	1	2	South Carolina	0	3	2
Kansas	0.2	2	2	South Dakota	1.6	0	2
Kentucky	0.2	2		Tennessee	0.3	1	
Louisiana	0.1	5		Texas	0.9	6	2
Maine	0.4	2		Utah	0	4	2
Maryland	0.1	7		Vermont	0	0	
Massachusetts	0	3		Virginia	2.5	0	2
Michigan	2.1	4	2	Washington	0	0	2
Minnesota	1.0	9	2	West Virginia	0	1	
Mississippi	*	1		Wisconsin	0.3	8	2
Missouri	*	3		Wyoming	0	0	

* Less than 0.1 %funded services with Medicaid.[d]

[a] Source: U.S. Census Bureau Survey of Local and State Governments, 1994-1995. Percentages represent "local share of welfare vendor payments," approximately 85 to 90 percent of which are payments to Medicaid providers.

[b] Source: Mathematica Policy Research one-page questionnaire sent to all state Medicaid directors, February 1998.

[c] Source: National Association of Counties Survey, 1996. Washington, D.C. (Reproduced in Appendix B.) Counties participate in Medicaid administrative costs more extensively than in program costs. See the NACO survey for details.

[d] Letter from Mary B. Kennedy, Minnesota Medicaid Director, to Michael Fiore, Acting Director, Division of Integrated Health Systems, Health Care Financing Administration. May 7, 1999. See also *State Health Watch.* "Devolution: It's not just for states

Administrative Capacity and Local Expertise

Local governments and agencies may have especially strong administrative capabilities and experience in selected functional areas related to Medicaid managed care, especially those that depend on extensive familiarity with local conditions and regular interaction with local beneficiaries and providers.

Beneficiary counseling and enrollment. Local entities often play a role in Medicaid beneficiary counseling and enrollment. Medicaid directors reported in the Mathematica survey that local governments played a role in eligibility determination in 14 states and beneficiary enrollment in 10 states. For instance, Utah relies heavily on county health department staff for managed care outreach and counseling. Nebraska terminated its enrollment broker contract and shifted responsibility to county health departments and county medical societies to expand an existing outreach program. Maryland has also engaged local health departments to assist in outreach.[a]

Monitoring. Medicaid directors in six states (Maryland, Minnesota, New York, Oregon, Pennsylvania, and Utah) reported in the Mathematica survey that local agencies—usually local public health departments—were involved in monitoring Medicaid managed care quality and access. This monitoring function may be a feasible extension of public health monitoring activities traditionally performed by local health departments in other states, as well.

Local expertise. Local governments may have a comparative advantage in performing functions that involve relationships with local providers—program design, contracting, network development, and quality and access monitoring—because of their familiarity with the strengths and weaknesses of these providers. (That familiarity also may lead to some conflict-of-interest problems, an issue that is dealt with in more detail in Section III.)

Local governments and providers may better understand local concerns about managed care, and be able to respond to them more effectively. If there is excess hospital bed capacity in an area, for example, but a shortage of neighborhood clinics, local people who know and trust each other may be able to shift resources from hospitals to clinics in ways that will be more locally acceptable than solutions developed by outsiders.

The county organized health systems (COHS) in California provide examples of this kind of local flexibility. The Orange County COHS (CalOPTIMA), which contracts directly for Medicaid services with consortia of physician groups and hospitals (as well as MCOs), makes separate capitated payments to the physician and hospital components of the consortia. It has recently followed a deliberate policy of increasing the physician share of these payments and reducing the hospital share, in order to encourage more primary and preventive care, and to compensate in part for the historically low physician reimbursement rates in the state's Medicaid program.[b] This shift may have been facilitated by the fact that there are no county-financed hospitals in Orange County.

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anymore—Counties seek role as Medicaid contractors" and "Minnesota waits for HCFA waiver approval allowing county-level Medicaid contracting." May 1999.

[a] Mary S. Kenesson. " Medicaid Managed Care Enrollment Study." Princeton, NJ: Center for Health Care Strategies, Inc., December 1997. Pp. 10-11.

[b] SCM & Associates and Pacific Health Consulting Group. "Selected Issues in the Development of County Organized Health Systems." Report IV of a series of reports on MediCal managed care models in California prepared for San Diego County and funded by the Alliance Healthcare Foundation. June 1999, p. 13.

Manageable Scale

Some states, such as California and New York, are so large in terms of population and/or geographic distance that local administration of Medicaid managed care may be more efficient and effective than state administration. There are more Medicaid beneficiaries in Los Angeles County and New York City, for example (about 1.8 million in each), than there are in any other state but Texas.[a] Local governments of this size can obtain the technical managed care resources they need as readily as state governments can. They also have enough Medicaid beneficiaries to give them negotiating leverage with MCOs, and to provide MCOs with the volume of enrollees they need to cover managed care administrative costs and spread medical risk.

At some point, state Medicaid managed care programs can become so large that diseconomies of scale may arise; Medicaid office staff may not be able to effectively keep track of activities in all areas of the state. Shifting some responsibilities to local levels of government may be one way of dealing with this problem, especially if the responsibility is relatively routine and easy to monitor, such as determining eligibility.

Local public health agencies may also be able assist in reviewing MCO quality and performance, especially if they have local staff with the necessary expertise and familiarity with local providers. Local agencies may have an advantage over state-level staff in on-site reviews of medical records and clinical activities. Again, however, as discussed further in Section III, there may be some problems with conflict of interest as well as confusion among MCOs with respect to whom they are accountable.

Preservation of Traditional "Safety Net" Capabilities

Local public hospitals, clinics, and health departments may be heavily dependent on Medicaid revenue to support care for the uninsured and other under-funded activities. MCOs, however, are generally not willing to pay these entities more than the cost of providing care to Medicaid beneficiaries in order to cross-subsidize other services. MCOs may also have other providers in their networks with whom they prefer to contract. In addition, when given a choice, Medicaid beneficiaries may prefer other providers. Thus, absent special arrangements in state Medicaid contracts with MCOs, these "safety net" providers may be vulnerable to loss of Medicaid patients and revenue.[b]

When these traditional safety-net providers are funded or staffed by local governments, the loss of Medicaid revenue may be especially problematic, since local government funding may have to be increased to make up for the Medicaid shortfall, local government jobs may be lost, and health care services that are important to the community may be diminished.

Under these circumstances, local officials faced with Medicaid managed care may exert pressure at the state level to obtain special consideration for local providers in the form of extra payments from the state or MCOs, requirements that MCOs include these local providers in their networks, or "carve-outs" of the local providers or their services from managed care.

Even if there is no significant pressure from local officials, state Medicaid agencies may wish to maintain these local safety net providers because of the access and care they provide to vulnerable populations who might not be as well cared for under alternative arrangements. For example, local safety

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[a] U.S. Health Care Financing Administration (www.hcfa.gov/medicaid), Medi-Cal Policy Institute (www.medi-cal.org/countydata), New York State Department of Health (www.health.state.ny.us/nysdoh/medstat/medicaid.htm).

[b] For more detail, see Solloway, Michelle, and Julie Darnell. "The Impact of Medicaid Managed Care on Essential Community Providers." Portland, ME: National Academy for State Health Policy, April 1998.

net providers may have developed relationships and linkages among other providers of medical, social, and ancillary services that facilitate care for parts of the Medicaid population that are especially vulnerable because of their complex health care needs, or specific social, economic, or cultural problems. As noted earlier, Minnesota has emphasized this aspect of county-based purchasing in its application for a Section 1115 waiver.

Local delivery systems may also have clinical capabilities and experience that generalist MCOs may not be able to match. Local community mental health centers, for example, may be more capable of meeting the special mental and behavioral health needs of the Medicaid population than an MCO whose main experience with mental health problems has been with enrollees who work for large companies. Oregon's gradually implemented hybrid approach to covering mental health services in managed care was prompted in part by concern about private MCO's lack of experience in dealing with the seriously and persistently mentally ill. A significant role has been maintained for county-based providers in that plan.[a]

Local Control and Autonomy

Local governments may also believe that state program designers and "outside" MCOs will not be sufficiently responsive to local concerns and the needs of the local health care market. Local governments in rural areas, for example, may fear that managed care requirements designed primarily for urban areas will be inappropriately applied in their areas. They may also fear that local health dollars will be shifted to other parts of the state. MCO administrative activities, for example, may be handled largely through a central office elsewhere in the state rather than locally. Retaining a large degree of local autonomy and control over Medicaid managed care is one way of responding to those concerns

Impact on Beneficiaries

MCOs and providers who are locally accountable may in some cases be more accessible and responsive to Medicaid beneficiaries, due to their close proximity to and familiarity with this population. Medicaid beneficiaries in general are not well organized, and are therefore not in an especially good position to influence public officials. The obstacles to beneficiary influence may not be as great at the local level.

As discussed further in Sections IV and VI, it may be easier for locally administered programs to link Medicaid managed care beneficiaries with social and ancillary services, since these services are often funded and/or operated by local governments.

Political Considerations

IV. **LOCAL ELECTED OFFICIALS WITH INFLUENCE IN STATE-LEVEL DECISION MAKING MAY HAVE CONCERNS ABOUT THE ALLOCATION OF STATE AND LOCAL MEDICAID MANAGED CARE RESPONSIBILITIES IN GENERAL OR IN SPECIFIC CASES. THESE CONCERNS MAY INVOLVE THE PROTECTION OF LOCAL GOVERNMENT OR HEALTH CARE PROVIDER JOBS, THE CONTINUED ACCESS OF MEDICAID BENEFICIARIES AND OTHERS TO APPROPRIATE HEALTH CARE, OR ANY OF THE OTHER CONSIDERATIONS OUTLINED ABOVE. THESE ISSUES TAKE ON AN EXTRA DIMENSION WHEN THEY ARE RAISED BY OFFICIALS WHO CAN INFLUENCE STATE DECISION MAKING BY GOING DIRECTLY TO THE LEGISLATURE OR THE GOVERNOR'S OFFICE. MANY STATE LEGISLATORS MAY HAVE PREVIOUSLY HELD ELECTIVE POSITIONS IN LOCAL**

[a] Agus, "County Role Changing as Oregon Takes Mental Health Managed Care Statewide; Mittler and Gold, "Managed Care for Low-Income Populations With Special Needs: The Oregon Experience."

GOVERNMENTS, AND MAY THEREFORE BE ESPECIALLY SYMPATHETIC TO THE CONCERNS OF THEIR FORMER LOCAL COLLEAGUES. STATE MEDICAID OFFICIALS MAY FIND THAT IT IS PRUDENT, IF POSSIBLE, TO RESPOND TO THESE LOCAL CONCERNS BEFORE THEY REACH HIGHER LEVELS.

CONSTRAINTS AND COMPETING CONCERNS

While there are a number of reasons why a state may want to involve counties and other local governments in the design and operation of Medicaid managed care, there are constraints and competing concerns that states also need to address, including federal Health Care Financing Administration (HCFA) regulatory and administrative requirements, state-level issues of administrative coordination and consistency, the administrative capacity of local governments, and the impact on beneficiaries and providers of divided state and local responsibility.

HCFA Requirements

There are a variety of HCFA regulatory and administrative requirements that state Medicaid agencies may have to deal with when allocating responsibilities for Medicaid managed care among the state and local governments. These include requirements that:

- The Medicaid program be administered by a "single state agency"
- Conflict-of-interest safeguards be built into the administration of the Medicaid managed care program
- Medicaid managed care procurements involve open and free competition "to the maximum extent practical"
- Medicaid managed care beneficiaries be allowed a choice of managed care plans

Single state agency. Under long-standing HCFA regulations, a single state agency must "administer or supervise the administration of" the Medicaid program. That agency "must not delegate, to other than its own officials, authority to (i) exercise administrative discretion in the administration or supervision of the plan, or (ii) issue policies, rules, and regulations on program matters."[a] There are thus limits on the extent to which a state Medicaid agency may delegate its managed care administrative and oversight functions to a county or other local government entity. HCFA may waive aspects of this single state agency requirement, as it has in the Section 1915(b) waivers under which the five county organized health system (COHS) managed care programs in California currently operate.[b] Nonetheless, the HCFA concerns that underlie the single state agency requirement—administrative efficiency and accountability—are likely to be raised whenever states propose to delegate managed care responsibilities to local governments.

In correspondence regarding Minnesota's request for a Section 1115 waiver for county-based managed care, for example, HCFA noted that:

> *As proposed, the State would maintain certain administrative and oversight functions, while delegating certain administrative and oversight functions to the county. This appears to*

[a] 42 CFR sec. 431.10.

[b] SCM & Associates and Pacific Health Consulting Group. "Development and Performance of County Organized Health Systems." Report II of a series of reports on Medi-Cal managed care models in California prepared for San Diego County and funded by the Alliance Healthcare Foundation. June 1999, p. 9.

result in an additional administrative layer between the beneficiary and the state. In addition, when assessing the models described in the amendment, this additional layer is also apparent in the flow of funds and service delivery, with the county serving as an additional presence between managed care plans and the state.

Another area of concern is the potential for duplication at the State and county level. We also believe that it may be difficult for the State to remain accountable for many of the functions that may be delegated to the county.[a]

Conflict of interest. Federal procurement regulations, which apply to state Medicaid managed care procurements, state that "No employee, officer, or agent shall participate in the selection, award, or administration of a contract supported by federal funds if a real or apparent conflict of interest would be involved."[b] If one of the reasons a local government wants to assume Medicaid managed care purchasing or contracting responsibilities is to assure that local providers are protected from loss of business to outsiders, or that local government jobs are protected, that is likely to raise HCFA concerns with respect to conflict of interest. As noted earlier, local governments often fund and/or administer local hospitals, clinics, public health departments and other health care providers; the potential for conflict of interest is especially high in those cases. Even apart from HCFA requirements, actual or perceived favoritism toward providers funded or administered by local governments could present political or public relations problems, undermine the willingness of MCOs and providers to do business with Medicaid, and even subject state or local governments to the threat of lawsuits.

Local government performance of administrative functions such as eligibility determination and beneficiary counseling may also raise conflict-of-interest concerns, since potential managed care enrollees could be "steered" to or away from local-government-supported MCOs or providers for reasons not solely related to potential enrollees' best interests. The 1997 Balanced Budget Act (BBA) contains a new provision dealing with conflict-of-interest issues in the context of Medicaid managed care enrollment.[c] HCFA raised this issue in discussions with Minnesota regarding the state's waiver request for county-based managed care. Minnesota proposed to address these concerns with arrangements for separate governance structures at the county level:

HCFA has expressed concern over the possibility of conflicts of interest when counties are responsible both for purchasing health care services and for enrollment and advocacy. Several of the proposed projects involve a joint powers board model. In these projects, responsibilities are clearly separated, with the joint powers board responsible for purchasing functions, while individual counties retain enrollment and advocacy responsibilities. Those projects that are based in a single county are required to demonstrate the separation of these functions.[d]

The California COHS managed care programs follow a similar approach to dealing with conflict-of-interest issues. Each COHS is governed by a board that is separate from the Board of Supervisors that governs the county as a whole. This approach, according to a recent report:

[A]llows the Board of Supervisors to create the program, maintain some control, but to keep an arms-length distance. [State] law provides for County "sponsorship" of the health system. The Board of Supervisors appoints a governing authority for a semi-autonomous

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[a] Letter to Mary Kennedy, Minnesota Medicaid Director, from Kathleen M. Farrell, HCFA Project Officer, April 27, 1999.
[b] 45 CFR sec. 74.42.
[c] Section 1932(d)(3) of the Social Security Act, added by Section 4707(a) of the BBA.
[d] Letter from Mary Kennedy, Minnesota Medicaid Director, to Michael Fiore, HCFA, May 7, 1999.

program. No more than two members of the commission may be members of the Board of Supervisors or their representatives. The Supervisors retain the right to terminate the program at any time and to appoint and reappoint Board members.[a]

The report notes that the Boards of Supervisors prefer this approach, since if they were directly responsible for administration they would be "subject to increased political pressure from providers, and health plan members, which could make objective management and policy setting difficult."

Competition. Federal procurement regulations require that "All procurement transactions shall be conducted in a manner to provide, to the maximum extent practical, open and free competition." This does not require that all Medicaid managed care procurements be done through a competitive bidding process. Many states award contracts to all willing and qualified MCOs. There have also been situations, such as the Oregon case discussed earlier, in which HCFA has allowed states to give at least a temporary preference or right of first refusal to locally based MCOs. If a procurement process systematically and indefinitely precluded non-local MCOs from participating in Medicaid managed care, however, HCFA approval would probably be less likely.

In making the case for its county-based managed care waiver request, Minnesota pointed out that there is an exception to the federal procurement regulations that could apply to their request. The relevant provision states that:

[R]equests for individual case deviations will be considered favorably by [the Department of Health and Human Services] and its awarding agencies whenever the deviation will facilitate comprehensive integrated service delivery . . . unless the deviation would impair the integrity of the program. (45 CFR sec. 74.4)

The state noted that its county-based program "was developed to address the sometimes fragmented system of public supports for [Medicaid] recipients. It is intended to test the efficacy of increased integration of medical services with other types of supports for families and individuals in need, offering an opportunity to promote coordination within the entire local delivery system."[b]

Minnesota argued that a competitive procurement would not be a practical way of achieving that goal, and that a sole-source arrangement was preferable:

The fundamental aspect of the . . . proposal is to improve the coordination of [Medicaid] coverage with other programs affecting health outcomes, such as public health and social services. Because county government is essentially the only entity within each geographic area that has those specific responsibilities under state law, counties are the only source.[c]

Choice of managed care plans. Section 1902(a)(3) of the Social Security Act (added by the 1997 BBA) requires that Medicaid beneficiaries have a choice of at least two managed care entities (two or more MCOs, or one MCO and a primary care case management [PCCM] program). The Act allows an exception for rural areas—a single MCO may be permissible if it allows a choice of at least two physicians or case managers, for example—but HCFA has not yet issued regulations spelling out the terms under which such exceptions may be granted. States may therefore have difficulty in persuading

[a] SCM & Associates and Pacific Consulting Group. "Development and Performance of County Organized Health Systems." Pp. 14-19 of the report contain detailed information on the composition of the governing boards in each of the five COHS programs.
[b] Letter from Mary Kennedy to Michael Fiore, May 7, 1999.
[c] Letter from Mary Kennedy to Michael Fiore, May 7, 1999.

HCFA that local managed care programs that include only one MCO comply adequately with the beneficiary choice requirement.

In defending its county-based proposal, Minnesota has noted that small populations and small numbers of providers limit the number of MCOs that can be successful in rural areas. In urban areas, they point out, county government procurements could result in awards to multiple MCOs, thus complying with the BBA choice requirements.

In California, the COHS programs function in some respects as a single MCO for the entire county. However, they often enter into multiple sub-capitation arrangements with individual physicians, multi-specialty physician groups, county and community clinics, physician-hospital consortia, hospitals, and full-service health plans.[a] From a beneficiary perspective, therefore, the programs look more like loosely organized preferred provider organizations (PPOs) that permit a fairly wide choice of providers. The current California COHS arrangements pre-date the BBA and have been specifically authorized by federal statute, so the choice-of-MCOs issue has not arisen.[b]

State Administrative Coordination and Consistency

Policy and administrative coordination is difficult even when only one level of government is involved. It can become especially difficult when separate levels of government with different agendas and priorities are involved, when there may be conflicts of interest between purchaser or administrator and provider roles, and when the decisions require a large measure of discretion and judgment.

If, for example, it is state policy that MCOs must offer certain types of safety net providers the opportunity to be included in MCO networks on the same terms as other providers, there is substantial room for judgment on what does and does not represent compliance with that policy. It is easy to imagine state and local officials coming to different conclusions on this issue in specific cases, potentially leaving MCOs in the middle.

Similarly, the state may require that local staff who enroll Medicaid beneficiaries and counsel them on their managed care choices provide neutral and unbiased information on those choices. Local officials may have a preference for some MCOs or providers over others, however, and may seek to have that preference reflected in the information local staff provides to beneficiaries on their choices. The steering that may result would be difficult for the state to prevent if local staff perceive themselves as working for local government rather than the state.

Even if there are no specific contractual requirements for consistency, it is usually problematic for government to treat people in inconsistent and seemingly arbitrary ways. If people in one jurisdiction perceive that someone in another jurisdiction is being treated better than they are, or is getting something they are not, they are apt to complain. Those who are responsible for running statewide programs try their best to minimize such occasions for complaint. Local officials, by contrast, are often rewarded for obtaining better treatment for their constituents than others are getting. Dividing responsibility for Medicaid managed care between state and local governments can increase these built-in tensions, with state legislators, governors' offices, and Medicaid agencies frequently being drawn in to sort out the conflicts.

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[a] SCM & Associates and Pacific Health Consulting Group. "Development and Performance of County Organized Health Systems." Pp. 41-47.

[b] For a discussion of the federal statutes and regulations governing California COHS arrangements, see SCM & Associates and Pacific Health Consulting Group. "Development and Performance of County Organized Health Systems." Pp. 7-10.

Locally based Medicaid programs may also present problems for beneficiaries who move from one county to another that are similar to those that arise when beneficiaries move from one state to another (need to re-enroll, differences in rules and requirements, and the like). Similarly, MCOs that operate in several local jurisdictions would likely find it costly and unwieldy to operate under different rules in each jurisdiction.

Data requirements. Medicaid managed care is a data-intensive business. Consistency and comparability in data requirements are important for both MCOs and administrative and oversight agencies. MCOs are generally expected to provide Medicaid agencies with encounter data, HEDIS data, complaint and grievance reports, enrollee surveys, financial reports, and a variety of other reports on services provided and organizational performance. MCOs that operate in a number of different states complain about data requirements that differ from state to state. The problem may be exacerbated if multiple jurisdictions within a single state require data in different forms and formats. State managed care monitoring and reporting will also be difficult if data are not available in consistent and comparable form from local jurisdictions.

Administrative Capacity of Local Governments

Administering a Medicaid managed care program requires experience and skills that are not always available at the state level, and that may be even harder to develop and maintain at most local levels because of their considerably smaller size and resource base.[a] Local governments may simply not be large enough to hire or pay for the administrative, information systems, contracting, rate setting, claims processing, monitoring, reporting, and analytic resources that are needed. As noted earlier, however, some local governments, such as Los Angeles County or New York City, have more Medicaid beneficiaries than almost all states, and governmental infrastructures that are larger and more well-developed than those of most states.

Some state Medicaid managed care programs operate with quite small staffs; there are at least eighteen states that have ten or fewer state staff devoted to managed care. Other states, by contrast, have over 100 (California, Minnesota, New York, and Oregon), while Arizona has over 1000.[b]

Leadership, experience, and expertise. The issue of administrative capacity goes beyond dollars and numbers of staff, although these are important threshold questions. The issue turns also on the level of local leadership and commitment, and on managerial and organizational experience and expertise. The expert panel convened by Mathematica in June 1998 included two local officials from counties with Medicaid managed care programs of very different size and scope: Carol Wallace, Commissioner of Social Services in Greene County, New York, and Estelle Richman, Commissioner of Health for the Philadelphia Department of Public Health. CalOPTIMA, which runs the Orange County, California, COHS, provides another example. Three themes emerge from these examples:

- Developing effective county-administered Medicaid managed care programs requires several years of preparation, along with top-level leadership and commitment.
- Local administration can sometimes allow greater flexibility in hiring and salary levels than is possible when Medicaid managed care programs are dependent on state-level personnel systems and salary scales.

[a] For a discussion of staff skills and experience needed to administer Medicaid managed care, and organizational design, recruitment, and retention issues, see James M. Verdier, "Restructuring Medicaid Offices to Deal with Managed Care," Princeton, NJ: Center for Health Care Strategies, Inc., January 1998.

[b] National Academy for State Health Policy. "Medicaid Managed Care: A Guide for States." Fourth Edition, March 1999, pp. I-D-83-92.

- Local administration can sometimes facilitate blending of Medicaid and non-Medicaid funding streams and coordination of social and ancillary services with Medicaid-funded services to a greater extent than may be possible with state-administered programs.

The three examples are described briefly below.

Greene County, NY. Greene County is a mostly rural county about 40 miles south of Albany. It has a total population of about 45,000 people, and fewer than 5,000 Medicaid enrollees.[a] Carol Wallace has been Commissioner of Social Services for over 17 years, and has strong local ties with all those likely to be affected by managed care. She volunteered her county to be the first in the state to do Medicaid managed care on a mandatory basis, beginning in January, 1997. The county had operated a risk-based managed care program on a voluntary-enrollment basis since 1991, and about half of those eligible for managed care were in the voluntary program at the time it became mandatory. The county legislature was very supportive of the move to mandatory managed care, and provided approval and funding for professional-level staff with clinical, management, and policy training. The union representative for the county was consulted and proved amenable to the approach of hiring staff from outside for these more specialized tasks.

Commissioner Wallace spent a great deal of time on staff training and on developing collaborative relationships with managed care stakeholders. While there are only two or three people on Commissioner Wallace's staff who spend full time on managed care, many others have been cross-trained to perform managed care functions. Commissioner Wallace set up two external advisory groups, one to deal with policy-level issues and the other to deal with more technical issues.

The county's primary Medicaid managed care responsibility is beneficiary enrollment and counseling, but it also shares responsibility with the state for managed care oversight ("We're the front line on quality," Wallace says), and can include specific additional terms and conditions in the contracts it signs with MCOs (mandating use of the local hospital, for example). The basic MCO contract is established by the state, which also has sole responsibility for rate setting.

Part of the reason for county government support of mandatory Medicaid managed care in Greene County is that it provided an opportunity for the county to obtain Medicaid funding for a portion of the costly Home Relief program, which had previously been funded 50 percent by the state and 50 percent by the county. By including the Home Relief population in Medicaid managed care, the funding split became 50 percent federal, 25 percent state, and 25 percent county. The Home Relief population has more complex medical needs (substance abuse, mental illness) than the AFDC/TANF and related populations. Medicaid SSI and related populations are not required to enroll in managed care in New York, although persons with HIV/AIDS and serious mental illness will be required to do so when Special Needs Plans become available. Greene County has therefore had only limited experience so far in including people with complex social and medical needs in managed care.

Philadelphia, PA. The city and county of Philadelphia has a population of nearly 1.5 million, with over 375,000 enrollees in Medicaid managed care.[b] Estelle Richman joined the Philadelphia Department

[a] Information in this section comes from Hilary Frazer's March 1998 telephone interview with Carol Wallace; the Mathematica June 1998 expert panel meeting; a July 15, 1999 telephone conversation between Jim Verdier and Carol Wallace; and the New York State Department of Health Web page(www.health.state.ny.us/nysdoh/research/medicaid.htm).

[b] Information in this section comes from Hilary Frazer's March 1998 telephone interview with Estelle Richman; the Mathematica June 1998 expert panel meeting; a July 23, 1999 telephone conversation between Jim Verdier and Estelle Richman; and Pennsylvania Department of Public Welfare, "HealthChoices: The First Year, February 1, 1997 to January 31, 1998." Publication 371, September 1998. The Ford Foundation and Harvard's Kennedy School of Government announced on October

of Public Health in 1989 as Director of Mental Health and was appointed Commissioner of Health in 1994. The Department of Health contracted with the state in 1997 to function as a risk-bearing behavioral health MCO in the Medicaid managed care program, the only county to take up the state's offer to assume this responsibility. (Other counties formed partnerships with private behavioral health MCOs.) The department began preparations for this effort a decade earlier, when the Robert Wood Johnson Foundation gave the department a grant to develop systems of care for the chronically ill. Commissioner Richman was involved in this effort from 1989 on, when she shifted from a state government mental health position to become Director of Mental Health for the city and county. When the grant ended in 1992, the department hired a full-time person dedicated to creating a managed care system. More staff was hired between 1993 and 1997. When the behavioral health managed care program began operations in 1997 there were about 30 people, and a year later there were more than 200. There are now about 260, and Commissioner Richman expects there to be nearly 300 by the end of 1999. The department set up a separate not-for-profit entity (Community Behavioral Health), which remains accountable to the department but is able to hire outside of the civil service system, which gives it more hiring and firing flexibility. (Community Behavioral Health uses the county salary and benefit schedule, which is more than competitive with the private sector at the front-line level, but less so at higher levels.) While Community Behavioral Health handles the Medicaid behavioral health funds, the department's Office of Mental Health handles mental health program funds for residential services, vocational, and other programs, and a separate office handles program funds for drug and alcohol programs. The department has organized itself so that these three separate program funding streams can be used collaboratively to create a system of behavioral care for Medicaid beneficiaries, even though the funding streams themselves remain separate for accounting purposes.

Orange County, CA. Orange County's Medicaid COHS (CalOPTIMA) has about 210,000 enrollees (85 percent of total Medicaid eligibles in the county), out of a total county population of over 2.7 million.[a] CalOPTIMA functions to some extent as a state Medicaid agency would in terms of managed care contracting and oversight, but also functions as a private sector MCO would in terms of network development, negotiation of payment arrangements, and payments to providers. CalOPTIMA began operating in April 1994 with an executive director (Mary Dewane) who had extensive managed care experience both at HCFA and in the Wisconsin state Medicaid program. She built up the program over several years, hiring top-level people with both federal and state government and private sector managed care experience. CalOPTIMA is not limited by state or county personnel rules or salary levels, and is thus able to compete effectively for staff. CalOPTIMA currently has a staff of nearly 260 people, most of whom have responsibilities related to the MCO business functions. Some staff also have the kinds of monitoring and oversight responsibilities that a state Medicaid agency would have.

The California state Medicaid agency[b] is responsible for managed care monitoring, but CalOPTIMA functions as "an extra set of eyes locally," according to Dewane. Managed care capitated rates for COHS plans are set by the California Medical Assistance Commission, which is separate from the Medicaid agency. CalOPTIMA negotiates its rates directly with the Commission, but the rates cannot exceed the Medicaid upper payment limit that is calculated by the Medicaid agency.

14, 1999 that the Philadelphia Behavioral Health System was one of ten national winners of the 1999 Innovations in American Government Award.

[a] Medi-Cal Policy Institute Web site (www.medi-cal.org/countydata), July 12, 1999. Other information in this section comes from SCM & Associates and Pacific Health Consulting Group. "Selected Issues in the Development of County Organized Health Systems," and from a July 19, 1999 telephone conversation between Jim Verdier and Mary Dewane, Chief Executive Officer of CalOPTIMA.

[b] The Department of Health Services. The California Medicaid program is called Medi-Cal.

CalOPTIMA is responsible for virtually all Medicaid eligibles in Orange County, including SSI and disabled populations. Some of the SSI and disabled populations who are administratively complex are allowed to enroll in fee-for-service or "loosely managed" managed care arrangements within the COHS, rather than in the risk-based arrangements that cover AFDC/TANF and related populations. Those given this option include foster children, Medicaire-Medicaid "dual eligibles," elderly nursing home residents, and those who must "spend down" their income to be eligible. Dewane believes CalOPTIMA does an effective job of coordinating the care of SSI and related populations and linking them to non-Medicaid social and ancillary services. She does not believe that is necessarily related to CalOPTIMA's links to county government, however. It is primarily a matter of "attitude, leadership, and goals." She believes a commercial MCO with no ties to local government could do the same thing if it wanted to and had appropriate financial and other incentives.

V. A FRAMEWORK FOR STATE AND LOCAL DECISION MAKING

State and local governments that are assessing their appropriate roles in Medicaid managed care can obtain some guidance from the experience of states in which local governments are playing significant roles in Medicaid managed care programs. However, these decisions are highly context-specific. Just because something seems to work in one state does not mean that it will work elsewhere. Approaches that were unsuccessful in one context may nonetheless be worth trying in another.

What follows is a check-list of questions that state and local officials can ask to make sure that they have not overlooked any major considerations. How the questions should be answered and how much weight should be given to the various often-competing considerations will have to be determined separately in each state and context.

Questions To Ask

These questions are separated into categories that correspond to the discussion in the preceding sections of this report.

Legal

- What does state law currently say about local government participation in Medicaid, managed care, and related activities?
    - Does it reflect current circumstances, or those of a pre-managed-care period?
    - If the latter, is there any support for changes?

Financial

- Do local governments currently provide significant funding or other support for Medicaid or Medicaid-related activities (enrollment, social and ancillary services)? Does the funding cover Medicaid administrative costs, program (service) costs, or both?
- Do local governments fund providers (hospitals, clinics, mental health centers) who might be adversely affected by Medicaid managed care?

Political

- Are local officials likely to have significant concerns about Medicaid managed care program design and implementation, and if so what are they likely to be?
    - What recourse do they have if their concerns are not addressed?

Economies and diseconomies of scale

- If local governments want to function as MCOs or managed care purchasers, are there enough potential Medicaid managed care enrollees over whom to spread medical risk and managed care administrative costs?
- Is the state so large, in population and/or geographic size, that localizing some aspects of Medicaid managed care purchasing or administration could be more effective than doing it at the state level?

Local administrative capacity

- Do local governments have or can they obtain the administrative resources (dollars and people) they would need to administer the portions of the Medicaid managed care program that may be delegated to them?
- Do local governments have or can they obtain more flexibility in hiring, firing, and compensation levels than state government?

Local expertise

- Do local governments have special expertise or experience in some important Medicaid managed care functions, such as beneficiary enrollment and counseling, or quality and access monitoring?
    - Are there potential conflict-of-interest problems that must be addressed?

Opportunities to blend funding and coordinate programs

- Do local governments have funding and/or administrative responsibility for social and ancillary service programs that could be more effectively coordinated with Medicaid if more responsibility for Medicaid managed care were delegated to the local level?

Impact on beneficiaries

- Can a strong case be made that Medicaid beneficiaries will be either helped or hurt by the proposed allocation of responsibilities between the state and local governments?

HCFA requirements

- Are the responsibilities contemplated for local governments consistent with the HCFA"single state agency" requirement?
    - Can HCFA concerns with potential duplication, overlap, and lack of accountability be effectively addressed?
- If local governments provide Medicaid services or fund local health care providers, could they comply with HCFA conflict-of-interest requirements if they were also responsible for

Medicaid managed care purchasing, enrollment and counseling of beneficiaries, care coordination, or monitoring of access and quality?

- Can HCFA requirements for competition in Medicaid managed care procurements "to the maximum extent practical" be met?

- Can beneficiaries be provided with the choice of Medicaid managed care plans that the 1997 Balanced Budget Act requires?

State administrative coordination and consistency

- Will state and local governments be able to speak with "one voice" on issues that are important to Medicaid providers, beneficiaries, and MCOs?

- Will state and local governments be able to achieve consistency in the data requirements imposed on Medicaid MCOs?

- Will the state be able to collect and report data that will permit consistent comparisons of the performance of MCOs and local governments throughout the state?

VI. EMERGING ISSUES

The role of local governments in Medicaid managed care within particular states will likely be determined in large measure by developments that are specific to those states. Nonetheless, states that are considering new or expanded roles for local governments will want to look in particular at states like Minnesota and Wisconsin (discussed below), which are attempting to fit some of these newer roles within HCFA requirements.

Two broader developments within Medicaid managed care may also affect future state and local thinking about the appropriate roles for local governments:

- **Potential impact of Medicaid-dominated MCOs.** Commercial MCOs appear to be losing interest in Medicaid, leaving more of the Medicaid business to Medicaid-only or Medicaid-dominated MCOs. These Medicaid MCOs are often made up primarily of local hospitals, clinics, health centers, and other "safety net" providers.[a] Local governments may perceive these "home-grown" MCOs as less threatening than outside commercial MCOs. If this trend toward locally based Medicaid MCOs develops in a particular state, it may reduce the concerns about private sector competition that have prompted some local governments to seek broader Medicaid managed care responsibilities. It may also facilitate many of the benefits of local accountability that local governments have sought from Medicaid managed care, without requiring direct local government assumption of managed care responsibilities. At the same time, increasing state dependence on Medicaid-only MCOs with strong local, financial, political and other ties may raise issues for states that are similar to those raised by local government responsibility for managed care functions.

[a] For more detail, see Robert E. Hurley and Michael A. McCue. "Medicaid and Commercial HMOs: An At-Risk Relationship." Princeton, NJ: Center for Health Care Strategies, Inc., May 1998; Alicia Fagan and Trish Riley. "Medicaid-Only Managed Care Organizations." Portland, ME: National Academy for State Health Policy, August 1998; Suzanne Felt-Lisk. "The Changing Medicaid Managed Care Market: Trends in Commercial Plans' Participation." Washington, DC: The Henry J. Kaiser Family Foundation, May 1999; Suzanne Felt-Lisk. "The Changing Medicaid Managed Care Market: The Characteristics and Role of Medicaid-Dominated Plans." Washington, DC: The Henry J. Kaiser Family Foundation, forthcoming August 1999.

- **Potential linkages with locally funded social and ancillary services.** States are seeking to extend Medicaid managed care to SSI and other disabled populations, who are much more dependent on locally funded and provided social and ancillary services than the generally healthy AFDC/TANF and related populations that were covered in the earlier stages of Medicaid managed care.[a] Involving local governments more extensively in Medicaid managed care could facilitate better links between Medicaid-funded services and these local services. It could also, however, generate even greater conflict over which level of government should be in charge.

These two issues are discussed further below, along with some possibilities for further research.

Potential Impact of Medicaid-Dominated MCOs

Medicaid-only or Medicaid-dominated MCOs have several potential advantages for both states and local governments:

- They can specialize in dealing with aspects of Medicaid managed care that commercial MCOs may be less able or willing to deal with, including frequent enrollee turnover, language or cultural issues, transportation problems, chronic illness and disability, mental health and substance abuse problems, specialized data and reporting requirements, and the like.

- They may have a greater long-term commitment to serving the Medicaid population, and thus be less likely to drop out in the face of short-term financial difficulties.

- They may be more accustomed to dealing with the special characteristics of publicly funded managed care programs (unpredictable rates, extensive reporting requirements, high public visibility).

- They may have well-established relationships with local providers of both medical and non-medical services that can facilitate better care coordination and cooperation.

- They may be able to develop relationships of trust and cooperation with local governments that can lessen the impact of concerns about managed care.

States also face potential risks in becoming overly dependent on Medicaid-only or Medicaid-dominated MCOs:

- The MCOs may be under-capitalized and thus unable to build the administrative and information systems infrastructure that is needed to effectively manage care and help assure access and quality, or to build up the reserves needed to withstand short-term financial fluctuations.

- They may be dominated by providers—especially hospitals—who are likely to resist the utilization management and cost containment steps that MCOs must take to free up resources for other higher-priority services or build adequate reserves.

[a] See, for example, Marsha Regenstein and Christy Schroer. "Medicaid Managed Care for Persons with Disabilities: State Profiles." Washington, DC: The Henry J. Kaiser Family Foundation, December 1998; James M. Verdier, Stephen A. Somers, and Valerie Harr. "Washington State's Experience In Extending Medicaid Managed Care To The SSI Population: A Retrospective Analysis." Princeton, NJ: Center for Health Care Strategies, Inc., August, 1998.

- They may have or develop such close ties with local and state political systems that it may become difficult to hold them accountable for performance, or to allow them to fail financially.

In some states, Medicaid-dominated MCOs may be an alternative or supplement to direct local government involvement in Medicaid managed care, since they may enable states and localities to achieve their goals of local accountability and responsiveness while complying more easily with HCFA requirements. Medicaid-dominated MCOs would generally not face the same conflict-of-interest problems local governments may encounter, for example. Having both a Medicaid-dominated MCO and a local government MCO in the same market would give beneficiaries the choice of managed care plans that federal law requires. Of course, whether this approach is feasible in specific states will depend on the characteristics of the Medicaid-dominated MCOs, the details of the local government alternatives being considered, and the goals that states and localities have for Medicaid managed care.

Possibilities for further research. Learning more about the characteristics and performance of Medicaid-only and Medicaid-dominated MCOs should be a high priority for Medicaid programs generally, since the implications go well beyond the state-local relationships discussed in this paper. In particular, further research is needed on the following aspects of MCOs that specialize in Medicaid and other public programs:

- Administrative and managerial infrastructure
- Information systems infrastructure, including ability to record and report encounter data
- Financial solvency
- Scope of provider networks, including specialists in chronic diseases and disabilities when needed
- Linkages with providers of non-medical social and ancillary services
- Internal care coordination capabilities, including links with physicians and community resources

Potential Linkages With Locally Funded Social And Ancillary Services

As states begin to extend Medicaid managed care to SSI and disabled populations, more effort will be needed to establish linkages between Medicaid and providers of social and ancillary services on which these populations rely.[a] Further, as Medicaid managed care is extended to cover long-term-care services, more extensive MCO resources will have to be devoted to coordinating care in a broader range of settings and minimizing inappropriate use of long-term institutional care, such as nursing facilities, and facilities for those with developmental disabilities or mental and behavioral health problems.[b]

There have been significant difficulties in establishing these linkages at the state level, even when the relevant state agencies have been part of the same umbrella agency. Much of the actual delivery of social and ancillary services takes place at the local level, where providers may operate with considerable

[a] See Verdier, et al. "Washington State's Experience In Extending Medicaid Managed Care To The SSI Population."

[b] For a discussion of some of these issues, see James M. Verdier. "Coordinating and Financing a Continuum of Services for Special Needs Populations in Medicaid Managed Care Programs." Draft report of the Financing Sub-Group of the Medicaid Managed Care Stakeholders Project, sponsored by the Center for Health Care Strategies, June 1999.

discretion and flexibility. It may therefore be possible for local governments to facilitate the links between Medicaid managed care programs and these other services more effectively than if the impetus must come from the state level. The extent to which this is feasible will obviously vary from state to state, depending on local governance structures, the extent of local control over program funding and operations, and the priority that state and local governments attach to strengthening these linkages to Medicaid managed care.

As discussed earlier, one of Minnesota's major arguments for its proposed county-based approach to Medicaid managed care is the potential for better coordination of county-funded social and ancillary services with Medicaid services under the county-based model. If Minnesota's Section 1115 waiver request is approved, other states considering similar approaches may be able to derive some lessons from Minnesota's experience.

Wisconsin long-term care reform model. Wisconsin is currently developing a Medicaid long-term care (LTC) reform model ("Family Care") that is designed to lead to better integration of locally provided services with Medicaid-funded services. In a July 1998 summary of the proposal, the Department of Health and Family Services noted:

> *Counties and tribes play critical roles in the current LTC system. They administer a variety of home and community-based programs for people who need LTC, including the Community Options Program and Medicaid home and community-based waiver programs, which are the major case-managed LTC programs currently in existence. They have established networks of home and community care providers, that could be the basis of an expanded network for the broader Family Care benefit. Most counties are also direct service providers, operating nursing homes, home health and personal care agencies, public health, and other services. County governments also have statutory responsibilities (e.g., under Chapters 51 and 55) for providing services to people with developmental disabilities or mental illness and other vulnerable adults.*
>
> *County government serves as the safety net for the protection of elders and other vulnerable adults against abuse and neglect. It also provides access to many public benefits (including eligibility determination), and is often a primary source of information to citizens about available services.*[a]

Under the proposal, counties would have a right of first selection to serve as either Aging and Disability Resource Centers (handling eligibility determination and beneficiary counseling) or Care Management Organizations (providing care for one or more target populations). The Care Management Organizations would be similar to risk-based MCOs, providing a full range of services for a fixed monthly payment per enrollee. To deal with HCFA concerns about potential conflict of interest between eligibility determination and provision of services, counties that want to perform both of these functions would have to set up new special-purpose districts to operate one of the two entities, while the other remains under traditional County Board governance. County Boards could appoint the members of the new special-purpose district, but could not govern it directly.[b]

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[a] Wisconsin Department of Health and Family Services. "Family Care: Redesigning Wisconsin's Long Term Care System." July 31, 1998, p. 48. Available on the department's Web page at www.dhfs.state.wi.us/LTCare.

[b] Letter of Health and Family Services Secretary Joe Leean to Joint Finance Committee members, February 22, 1999. Available on the department's Web page.

Possibilities for further research. States and local governments are still in the early stages of developing workable models of care coordination and service linking that include both Medicaid-funded and other services. There are several potential obstacles to success, including:

- The Medicaid upper payment limit (UPL), which limits the Medicaid capitated payments that states may make to MCOs to what it would cost to provide the same services to an actuarially equivalent population group under the Medicaid fee-for-service program.[a] This means that funding for care coordination, service linking, and non-Medicaid services may have to come from savings from reduced utilization of institutional services and from other managed care efficiencies.[b]

- The difficulty of blending funding streams and responsibilities when programs have different funding sources, different rules and requirements, and/or are in different agencies.

- The reluctance of individuals and organizations to give up authority or change established ways of doing things, whether at the state or the local level.[c]

Nonetheless, case studies that examine instances in which this kind of care coordination and/or blending of Medicaid and non-Medicaid funds has been successful could provide models for other states and local governments.[d]

VII. CONCLUSION

States and local governments that are considering their appropriate roles in Medicaid managed care should focus on their resources and goals, and on the context in which they will be operating. While capacity and experience is important in all cases, other constraints and competing concerns will vary with the specific roles that are envisioned for local governments and the goals states and localities aim to achieve.For example:

- **Purchaser.** Functioning as a Medicaid managed care purchaser at either the local or state level requires substantial administrative resources, skills, and experience. Conflicts of interest may arise if local government is also a service provider or funder.

- **Administrator.** Performing administrative functions such as eligibility determination, beneficiary counseling, care coordination, and monitoring of access and quality may build on local strengths and experience. Conflicts of interest may arise if the local government is both a beneficiary counselor or a program monitor and also a Medicaid service provider, but care coordination may be more effective if the local government administers or funds a variety of Medicaid and related services.

- **Provider of services.** Providing Medicaid services or funding service providers may be what prompts local government interest in performing Medicaid managed care purchaser or

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[a] 42 CFR sec. 447.361.

[b] For further discussion of this issue, see Verdier, "Coordination and Financing a Continuum of Services for Special Needs Populations in Medicaid Managed Care Programs."

[c] This is not a new problem. See the excerpt from Niccolo Machiavelli's *The Prince* (1532), cited in James M. Verdier. "Implementing Medicaid Managed Care Amid Skepticism Anxiety, and Controversy: Suggestions for Program Design, Monitoring, and Reporting." Princeton, NJ: Center for Health Care Strategies, November 1997, p. 1.

[d] Some examples are discussed briefly in Verdier, "Coordinating and Financing a Continuum of Services for Special Needs Populations in Medicaid Managed Care Programs."

administrator functions, but performing some of these dual roles may raise significant conflict-of-interest issues.

Local governments that want to assume Medicaid managed care responsibilities because they think doing so will protect them (and local service providers) from private-sector competition should realize that HCFA purchasing and conflict-of-interest regulations may prevent them from reaching that goal. They should also consider whether the threat of private-sector competition is as great now as it appeared to be a year or two ago. States that want to shift Medicaid managed care financial and administrative responsibility to local governments because they believe it may lessen the burden at the state level should realize that divided responsibility brings problems of its own, and that HCFA regulations require that the state remain ultimately accountable.

Those states and localities that want to share responsibilities for Medicaid managed care because doing so would build on local strengths, make Medicaid more responsive to local conditions, and make the program work better for beneficiaries will likely find that there are ways of accomplishing those goals that will comply with federal regulations and result in a Medicaid managed care program that meets the needs of their state and its citizens.

APPENDIX A

LIST OF ATTENDEES

EXPERT PANEL

JUNE 23, 1998

Expert Panel
The Role of Local Government in Medicaid Managed Care
June 23, 1998

Teresa Coughlin
Senior Research Associate
The Urban Institute

Jim Fossett
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Director, Quality and Performance Management Group
Health Care Financing Administration

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Robert Pestronk
Genesse County Health Officer
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Kevin Piper
Vice President, Alpha Center

Estelle Richman
Commissioner of Health
Philadelphia, PA

Stephen Somers
President, Center for Health Care Strategies

Carol Wallace
Commissioner of Social Services, Greene County, New York