Collaborating with Managed Care Organizations for Mammography Screening and Rescreening

Guidance for NBCCEDP Grantees

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

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Introduction

Scientific evidence from clinical trials shows that mammography screening among women aged 50–69 years can reduce mortality from breast cancer by as much as 30% to 40%. To achieve the national goal to reduce morbidity and death from breast cancer, more complete mammography screening coverage is needed among older women in every community across the United States. While scientists and public health professionals agree that women aged 50 years and older should receive mammography screening every 1 to 2 years, research shows that many women who most need screening do not receive it. This is especially true of women in low-income and vulnerable populations.

The U.S. Public Health Service developed the *National Strategic Plan for the Early Detection and Control of Breast and Cervical Cancer* to ensure that targeted women receive regular screening for breast and cervical cancer with prompt follow-up, if necessary. Enactment of the Breast and Cervical Cancer Mortality Prevention Act of 1990 authorized the Centers for Disease Control (now the Centers for Disease Control and Prevention) (CDC) to implement program activities recommended in the National Strategic Plan through partnerships with state and local health agencies and other organizations. In response to this congressional mandate, CDC established the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Currently, all states, the 5 territories, and 25 American Indian tribes are funded by CDC to establish and manage comprehensive breast and cervical cancer screening services for women who are minorities, low-income, and aged 50 years or older.[1]

Although mortality is higher for these targeted women, they seek mammography screening less frequently because of barriers such as fear and anxieties; the lack of provider recommendation and awareness; limited access due to cost or transportation; language, literacy, or cultural barriers; and the lack of time for working women. To date, most grantees have ensured screening and follow-up through direct service delivery or by developing provider networks in the public, nonprofit, and private sectors. The changing health care environment—in particular, the advent of managed care—offers new opportunities and challenges for these grantees, as it does for their peers in all public health organizations whose

[1] *Announcement Number 474: 1994 National Breast and Cervical Cancer Early Detection Program*. Washington, DC: Department of Health and Human Services; 1994.

programs target the needs of vulnerable populations. In many states, Medicaid managed care programs are transferring responsibility for comprehensive medical care, including prevention services, to private managed care organizations (MCOs). And the potential expansion of private MCOs to underinsured and uninsured people and the increasing prominence of Medicare risk contracts ensure that, in time, NBCCEDP target populations will be enrolled in these types of arrangements. The introduction of these new, significant players is likely to alter not only screening and referral practices for targeted women, but also grantee efforts in comprehensive community needs assessment and surveillance related to breast and cervical cancer.

In this changing health care environment, there are numerous opportunities and incentives to build productive partnerships between NBCCEDP grantees and MCOs to coordinate and collaborate in the delivery of mammography screening and breast cancer early detection services to older women. NBCCEDP grantees have been addressing the challenges of serving underserved and special populations, such as communities of color and women with low incomes, low literacy, or cultural or language barriers. They are more experienced in traditional public health functions such as community assessment and health planning, outreach to high-risk population groups, public education, community-based coalitions, professional education, population-based surveillance and tracking systems, and partnership development. In contrast, MCOs have more experience in the delivery of clinical services, including diagnosis and treatment, and have the advantage of a defined patient population for conducting evaluation research. Partnerships between public health and managed care organizations would benefit women by leveraging the assets of each partner.

In February 1995, CDC's National Breast and Cervical Cancer Early Detection Program commissioned Macro International Inc. to examine ways in which NBCCEDP's network of state, tribal, and territorial grantees could better collaborate with MCOs to reach the program's goals regarding mammography screening and rescreening. The project resulted in two products. The first is a guide detailing successful strategies in use by NBCCEDP grantees to recruit women for screening and rescreening. The guide will disseminate innovations among NBCCEDP grantees and profile the types of roles grantees might play in collaborations with private sector organizations that are assuming responsibility for care of the low-income and underserved women that the NBCCEDP program targets.[2] This paper is the second product. Its purpose is to provide useful background to set the stage

[2]Centers for Disease Control and Prevention. *Reaching Women for Mammography Screening: Successful Strategies of National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Grantees.* Atlanta, GA: Centers for Disease Control and Prevention; August 1997.

for collaborations between health plans and NBCCEDP grantees both for one-on-one clinical prevention and for communitywide prevention efforts. After summarizing key trends in the health care environment, the paper describes challenges and opportunities presented by managed care for the major components of clinical prevention services programs such as breast and cervical cancer prevention and control. It then explores ways in which MCOs, operating on their own, are addressing clinical prevention with their enrollees and for the community at large, followed by some examples of current collaborations. The final section presents some of the factors that make collaboration difficult as well as those that can enhance future collaborations and provides some "next steps" NBCCEDP grantees can take with health plans in their areas.

The Changing Health Care Environment

Before the advent of managed care, the world of health care reimbursement was much simpler, dominated as it was by indemnity insurance. In most indemnity insurance plans, the employer (usually matched by employee contributions) paid premiums to the insurance company; employees sought care from whatever provider they wished; and providers submitted claims to the insurance company and received reimbursement for each service based on their actual charges or a fee schedule. While the system offered unrestricted access to providers, the fee-for-service mechanism, many believed, contributed to overuse of tests and other health care services. In addition, few indemnity insurance plans reimbursed for prevention services.

As early as 1929, the Ross-Loos Clinic in Los Angeles—and more significantly, the Kaiser Corporation during World War II—introduced prepaid group practice models that turned the traditional reimbursement model on its head. These prepaid group practices, the forerunners of the modern staff or group model health maintenance organization, integrated health insurance and delivery of care into a single organization. By paying providers a salary or reimbursing them on a global per-enrollee basis (capitation), these plans aimed to encourage comprehensive care with a focus on prevention and early intervention. Today, traditional indemnity insurance models are rapidly being eclipsed by managed care models. Enrollment in health maintenance organizations (HMOs), the most developed type of MCO in the United States, grew from 6 million enrollees in 1976 to 51 million in 1994, mostly at the expense of traditional indemnity insurance plans.

More recently, the managed care landscape has become infinitely more complicated, with a proliferation of models and a blurring of the concept of managed care. The models grouped under the general term "managed care," while quite diverse, intersect at four points. All integrate financing and delivery of health care services through:

- **Contracts with providers.** The providers in some MCOs are salaried employees; in others, there is a fee-for-service contract.

- **Utilization controls on providers.** These controls may specify when, who, and how to refer, and they usually involve a "gatekeeping" primary care physician who provides continuity of care.
- **Financial incentives for enrollees.** These incentives encourage enrollees to use the providers within the MCO; they vary from no ability to go outside the network to higher copayments for use of out-of-plan providers.
- **Financial risk-sharing by providers.** At one extreme is full-risk capitation, in which the provider must care for enrollees without exceeding the capitation budget. Usually, the primary care providers are capitated, but some specialists may be capitated as well. Even when providers are not capitated, they share financial risk by discounting their fees or agreeing to have reimbursements withheld unless the plan meets utilization goals regarding hospitalizations or diagnostic testing, for example.

In general, four types of managed care models predominate:[3]

- **HMO: Staff/group model.** Patients use physicians who are directly employed by the HMO or contract only with the HMO. The providers are paid a salary or capitation. Enrollees may use only the HMO's physicians.
- **HMO: Independent practice association (IPA) model.** Patients use a network of physicians in private practice who contract to see patients from one or more HMOs. Providers are paid on a fee-for-service (FFS) or capitation basis.
- **Preferred provider organizations (PPOs).** PPO patients may use the organization's network of physicians, as in an IPA, or they may use physicians who are not in the PPO network; in the latter case, however, they usually incur a deductible or higher copayment or both.
- **Point of service (POS) plans.** Members of POS plans do not have to choose how to receive services until they need them. This type of plan usually enrolls members in both an HMO and an indemnity plan. As in a PPO, financial incentives encourage POS patients to use the HMO providers.

In practice, however, these are not discrete models; most managed care companies are evolving into "mixed-model" plans, offering a combination of options. Indeed, because staffmodel enrollment has been basically flat in recent years, despite the overall growth in HMO enrollment, many staff and group model plans are broadening their offerings to include more open-ended options.[4]

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[3]See the glossary in the Appendix (p. 35), for more information on these models.

[4]The American Association of Health Plans (AAHP) estimates that fully 80.5% of its member plans were offering POS or open-ended products in 1996, an increase from 55% in 1993. American Association of Health Plans (AAHP). *HMO/PPO Trends Report 1995*. Washington, DC: AAHP; 1995.

MANAGED CARE IN THE PUBLIC SECTOR

The public sector was slower to adopt the managed care trend, in part because of restrictive rules in Medicaid that were intended to protect Medicaid beneficiaries from exploitation. But in 1981 and again in 1993, the federal government allowed states to waive restrictions such as the freedom to choose providers and the requirement that all innovations be offered statewide.[5] State governments, in efforts to control their Medicaid budgets, are adopting managed care models in increasing numbers. As of June 1994, 43 states, the District of Columbia, and Puerto Rico reported at least one managed care program for Medicaid beneficiaries; and 23% of all Medicaid beneficiaries were enrolled in such programs, compared with 14% in 1993.[6]

Medicaid managed care has tended to encompass different models than the private sector. For example, there are few PPO or POS models among Medicaid managed care plans because, among other reasons, federal regulations prohibit the extensive cost-sharing with enrollees on which these models depend. Furthermore, the full-risk capitation plans are among the fastest growing. Indeed, the percentage of Medicaid enrollees in full-risk capitation plans (17 percent) exceeds the percentage of private HMO enrollees in these types of plans (15 percent).[7] Three models of Medicaid managed care predominate:

- **Full-risk capitation programs.** These are closest to traditional private HMOs. States contract with HMOs or other prepaid health plans on a full-risk basis. The managed care entity receives a capitation payment and is responsible for all care rendered to the enrollees. More than half of states (27) have a full-risk capitation program in place, and 10 offer only that program.
- **Partial capitation programs.** States contract on a capitation basis as in the full-risk models, but the managed care entity is responsible for only a specific set of services. For example, the provider may be at risk for all outpatient services, but receive payment for inpatient care on a fee-for-service basis. Other partial capitation programs may address only specific services such as mental health or substance use. Ten states have a partial-capitation program in place; two offer only this model.
- **Primary care case management (PCCM).** This is the loosest form of managed care currently used with Medicaid populations. The state recruits primary care providers and pays a small per-person fee for case management[8] of the enrollees' care. All services are reimbursed on a fee-for-service basis. The case management fee is an additional incentive for private physicians to serve Medicaid patients. Theoretically, cost savings are achieved by requiring case manager authorization of all services. PCCM is the most commonly used model; 31 states include a PCCM program among their multiple managed care options, and 14 offer only a PCCM program.

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[5]Waivers are granted under two sections of the Social Security Act. Section 1915(b) was enacted in 1981, these programmatic waivers allow states to waive certain provisions of the Social Security Act to facilitate the expansion of managed care. Section 1115, research and demonstration waivers, require a rigorous research design, are usually statewide in focus, and are viewed as harder to obtain than 1915(b) waivers.

[6]Description of Medicaid managed care models and enrollment estimates are drawn from HCFA data and other sources cited in: National Institute for Health Care Management. *States as payers: Managed care for Medicaid populations*. Washington, DC: Lewin-VHI, Inc.; 1995.

[7]Ibid.

[8]As used here, "case management" refers to the "gatekeeping" function assumed by the primary care provider, who approves and monitors all covered services for the patient.

The distinctions among managed care models are important because the type of plan is related to both the quality of data collection and openness to collaboration (informal or formal) with local health agencies. For example, staff and group models, because they work exclusively with a small number of providers, often have centralized data systems that make it easier to track prevention services and relate prevention services to health outcomes. On the other hand, these closed systems may be less likely to include outside agencies, such as health departments, in their provider networks. IPA, PPO, and POS plans build networks of providers, and their providers are accustomed to interacting with multiple health plans. These models may be more receptive to informal or even contractual agreements with health departments and other health agencies for selected services.

How Managed Care Impacts Clinical Prevention Services

While discussions of the potential impact of managed care on clinical prevention tend to emphasize threats, the evolving managed care environment presents opportunities as well as challenges for public health. This section examines both.

General Issues and Challenges

Most comprehensive, clinical, prevention services programs encompass service components such as outreach, screening (or other clinical contact), case management and follow-up, and either referral or treatment. In addition, there is an underlying infrastructure of public and professional education, capacity building, and coordination. Also, data generated by each service component help assess progress on community health and inform future service delivery.

Theoretically, service delivery and even the infrastructural functions can be assumed by someone other than the public sector. Nevertheless, many public health practitioners fear that transferring care of Medicaid and other vulnerable populations to private MCOs will disrupt service delivery and core public health functions. Macro International's previous work[9, 10, 11] indicates that privatization may be most disruptive for programs where:

- Service delivery has been based in the public sector.

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[9]Chapel T. *Medicaid Managed Care and Public Health Practices: The Case of Lead Poisoning Prevention*. Atlanta, GA: Centers for Disease Control and Prevention; 1995.

[10]Chapel T, Rutsch C, Miller A. *Working Collaboratively With Community-Based Organizations to Achieve Public Health Objectives*. Atlanta, GA: Centers for Disease Control and Prevention; 1995.

[11]Chapel T. *The Effect of Health Reform on Health Information Systems and Ability to Measure Prevention Effectiveness.* Atlanta, GA: Centers for Disease Control and Prevention (in progress; completion expected March 1997).

- Target audiences have been low-income or vulnerable populations.
- Class or race/ethnicity barriers exist between providers and recipients.
- Reporting is voluntary or reporting mandates are poorly enforced.
- Providers are confused or disagree about appropriate care.

In programs for Medicaid and other vulnerable populations, private plans are assuming responsibility for new types of clients with multiple problems who are unlikely to seek care without aggressive outreach. Without financial inducements, reporting mandates, or quality assurance standards to nudge the private providers, they may lack resources or incentives to pursue these new clients in the comprehensive way that public health agencies have.

LESSONS FROM OTHER PROGRAMS

The experiences of childhood lead poisoning prevention programs may be instructive. The shift to private managed care in many states has led to either actual declines in the numbers of children screened or, at least, no discernible increase in the numbers of children screened by private providers. The reasons, equally applicable to cancer prevention and control programs, include:

- Lack of consensus among providers on the necessity of screening. Busy providers leave lead screening out if they believe few children are at risk.
- Complicated reporting/documentation requirements and slow reimbursement. Again, if the providers do not believe lead poisoning is a problem, and conducting the testing delays reimbursement for services, then they are unlikely to do the screening and paperwork.
- Poor outreach. Lead problems are clustered in certain areas and among certain populations. Outreach is complicated and community-based; provider practices are simple and office-based.
- Poor data. In many states, it is difficult to know whether children have not been screened, or have been screened but the private screens not reported. The claims data system cannot identify these detailed services.[12]

[12]Chapel 1995. Op.cit. (footnote 9).

As states develop contracts for Medicaid and other special groups, they need to ensure that (1) contracts require and pay for the augmented special services that may be needed to reach out, engage, and follow up with low-income and special populations; (2) MCOs provide training or a backup system of support services, or both, for providers dealing for the first time with special populations; (3) quality assurance mechanisms are able to identify providers who are not extending the necessary support services; and (4) some dedicated funding for core public health services has been retained.

Conversely, managed care offers a medical home to those whose care has traditionally been episodic and fragmented. Stable relationships with providers present opportunities for coordinated and comprehensive prevention and early detection. Community-minded health plans may also provide needed resources, staff, and expertise for assessment, public education, and professional training. They may prove powerful allies in building community coalitions and especially in collecting provider data for assessment and surveillance.

Wise public sector organizations will find opportunities to support health plans. Evidence to date, though scant, indicates that private sector organizations need and want support. Orbovich found that health plans were looking for "bricks and mortar" clinic networks they could use for service provision to special populations; access to on-site social, medical, and health services that low-income people need; wraparound and enabling services such as transportation, case management, translation, and links to entitlements; and access to partners who were culturally competent and familiar with chronic conditions.[13]

Issues and Challenges in Breast and Cervical Cancer Control

While NBCCEDP grantees currently serve few Medicaid clients, changes in the health environment are pertinent to them as well. Many states are expanding managed care models to include the underinsured or uninsured, and Medicare risk contracts are becoming an important alternative in most states.[14] NBCCEDP is charged with establishing "a comprehensive public health approach to reducing breast and cervical cancer morbidity and mortality through screening, referral and follow-up, public education, professional education, quality assurance, surveillance and evaluation, coalition-building, and cancer plan development, and to pay for the screening of women who are unable to afford these services."[15]

Fulfilling most of this charge will require grantees to build relationships across private and public sectors. Most grantees can build on the base of private providers in their funded networks; the challenge is incorporating and making accountable those private providers who are not funded. Working through an MCO may make this harder or easier depending on its level of standardization and centralization as well as provider willingness to adhere to MCO guidelines. Because grantees give priority to women who are low income, uninsured, underinsured, racial minorities, or Native American, special attention must be paid to educating and building formal and informal relationships with MCOs in outreach, case management, and follow-up. Grantees will also need to work with plans, alone and as a group, to ensure adoption of uniform guidelines for screening.

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[13]Orbovich C. "Collaborative Strategies for Success in the Changing Medicaid Market: The Perspectives of Community-Based Providers and Managed Care Organizations." Prepared for AAHP and HRSA conference, Collaborative Strategies for Success in the Changing Medicaid Market. Washington, DC: Centers for Disease Control and Prevention; April 1–2, 1996.

[14]A survey by the American Association of Health Plans (AAHP) indicates that more than three-quarters (77.6%) of its member plans either have developed Medicare risk contracts or will develop them this year. *HMO/PPO Trends Report 1995*. Washington, DC: American Association of Health Plans; 1995.

[15]Department of Health and Human Services 1994. Op. cit. (footnote 1).

While managed care presents challenges, it also offers many opportunities to enhance both treatment and infrastructure for breast and cervical cancer control. An MCO medical home can offer comprehensive cancer care and comprehensive women's care that are hard to accomplish in the fragmented, categorical grant-funded environment. And both sectors will benefit from data partnerships, with grantees sharing their knowledge of important data elements and health plans offering incentives and sanctions to providers to provide data. As enrollments stabilize and plans are less consumed by enrollment and billing issues, their participation in communitywide efforts may increase. Where competitive issues can be overcome, health plans may become active members of coalitions and planning efforts.

Current Health Plan Prevention Efforts

While managed care and capitated reimbursement offer obvious incentives to use prevention and early detection to reduce the demand for expensive acute care, the literature on involvement of managed care organizations in prevention is mixed. On the one hand, HMOs have historically provided better first-dollar coverage and greater benefits for prevention services than traditional fee-for-service arrangements.[16] HMOs are more likely to cover preventive and reproductive health services than are other insurers. This is reflected in higher usage rates for services such as Pap tests, especially compared with Medicaid patients and uninsured women.[17, 18] Also, women enrolled in HMOs are least likely to incur the out-of-pocket costs that might deter seeking prevention services.[19]

On the other hand, Heiser et al. found that only a minority of HMOs had made significant investments in clinical prevention programs for their enrollees.[20] And Macro International[21] has found even less involvement in communitywide initiatives than in enrollee-based programs. Several similar factors seem to be responsible for HMOs' slow pace in adopting public health and prevention approaches for both enrollees and the community:

- **Timing.** Managed care and, in particular, full-risk capitated reimbursement have not yet become major parts of the payor mix for most private health care providers, even if the MCOs to which they belong are being paid on a capitated basis.

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[16] *HMO Industry Profile 1994.* Washington, DC: Group Health Association of America; 1994.

[17] Makuc D, Freid VM, Parsons PE. Health insurance and cancer screening among women. *Advanced Data in Vital and Health Statistics,* No. 254, Hyattsville, MD: National Center for Health Statistics; 1994.

[18] U.S. Department of Health and Human Services. Trends in cancer screening—United States, 1987 and 1992. *Morbidity and Mortality Weekly Report* 1996;45(3):57–61.

[19] Sonnenstein FL, Ku L, Schulte MM. 1994. Reproductive health care delivery—Patterns in a changing market. *Journal of Western Medicine* 1995;163:7–14.

[20] Heiser N, St. Peter R, Gold M, Corrigan J. *Promoting the Use of Prevention Services for Women and Children in Managed Care Plans: A Preliminary Look.* Report submitted to the Commonwealth Fund. Washington, DC: Mathematica Policy Research, Inc.; 1995.

[21] Chapel, T. *Privatization of Traditional Public Health Activities: The Effect on the Practice of Local Public Health.* Atlanta, GA: Centers for Disease Control and Prevention; 1996.

- **Confusion about federal health reform.** The Clinton administration's proposed Health Security Act had as central tenets universal coverage and service provision through large integrated service networks. This led forward-thinking organizations to forge relationships with alternative delivery settings in the community, such as community health, church-based, and public health clinics. The demise of this legislation in its original form and the slow pace of state initiatives have sidetracked these efforts.
- **Market conditions.** Most markets are highly competitive. Pressures on premiums leave little excess revenue to support extensive prevention for enrollees, much less for community initiatives that may also target nonenrollees. Nor are purchasers willing to pay higher premiums for prevention efforts without immediate payoffs.
- **"Show-me" attitude toward prevention.** Even in the long run, not all prevention efforts pass muster as cost-saving strategies for health care providers. While good for society as a whole and for employers who realize reduced absenteeism and increased productivity, few preventive efforts benefit the individual health care provider sufficiently to warrant major investment of the organization's resources.

Nevertheless, HMO adoption of prevention approaches is expected to accelerate. Studies have shown that even where incentives such as first-dollar coverage encourage enrollees to seek prevention services, many nonfinancial barriers reduce their compliance with prevention services guidelines.[22] As a result, health plans (especially HMOs) are increasingly stressing health outcomes and clinical care management. This trend is in response to purchaser influence, growing demand for accreditation by organizations such as the National Committee for Quality Assurance (NCQA), and accountability through HEDIS (Health Plan Employer Data and Information Set) reporting.[23] NCQA accreditation standards, for example, require plans to adopt practice guidelines for prevention services, inform providers of them, inform members about health promotion and prevention services available through the plan and encourage their use, and assess performance in at least two prevention service areas.

Managed care plans with disease prevention programs for women typically have mammography programs.[24] Breast cancer prevention and control are among the most common initiatives because the issue of breast cancer is prominent; research indicates the efficacy of early detection, guidelines for screening exist, screening

[22]Lieu T. Risk factors for delayed immunizations among children in an HMO. *American Journal of Public Health* 1994; 84(10):1621–1625.
[23]*Standards for Accreditation of Managed Care Organizations: 1995 Edition.* Washington, DC: National Committee for Quality Assurance; 1995.
[24]Heiser et al. 1995. Op. cit. (footnote 20).

generates lab reports or claims that make breast cancer relatively easy to track, and mammography and Pap smear rates are usually indicators in quality assurance report cards.

There is no single source of information on the activities of managed care organizations in the area of breast and cervical cancer prevention. However, a recent Commonwealth Fund symposium offers current insights into what the most sophisticated managed care organizations are doing.

The Fund convened approximately 50 experts from academia, research, and health plans to discuss how health plans view and accomplish prevention. Breast and cervical cancer were used as the focal point for the broader discussion because they were universally accepted as beneficial, were HEDIS measures, and were part of the health plan's experience. Plan representatives were drawn mainly from exemplary plans that had been identified during the research as having innovative approaches to prevention. The centerpiece of Commonwealth's efforts were case studies and a cross-site analysis of seven plans conducting innovative activities in breast and cervical cancer control and prevention. The case studies identified plan activities as well as a series of challenges faced by plans in getting data, using data, and engaging providers.[25]

Several patterns emerged in the strategies employed by the health plans participating in the Commonwealth Fund symposium. First, most are data-driven and office-based. This is a luxury that managed care organizations (especially staff and group model HMOs) have that may not be shared by private providers in the community or even, in the future, by IPA-model HMOs. HMOs with automated medical records or the ability to link their enrollment data to claims or laboratory data are in a unique position to monitor receipt of mammography by high-risk women. However, because women enroll in and disenroll from programs, and because many plans' screening guidelines call for mammography every 2 years, newly enrolled women in need of screening may be missed in a review of the enrollment database. In addition, comprehensive data bases are dependent on supplementary sources such as risk assessment surveys to collect all the desired information on the women. Even there, however, MCOs may have an advantage over the solitary provider in the community or the public sector program that is responsible for screening but not treatment, in that the audience is captive and opportunities abound to collect missing information and promote response to surveys.

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[25]Heiser N, St. Peter R. *Improving the Delivery of Clinical Prevention Services to Women in Managed Care Organizations: A Case Study Analysis.* Report submitted to the Commonwealth Fund. Washington, DC: Mathematica Policy Research, Inc; 1997.

MCO Approaches to Breast and Cervical Cancer Prevention

Health plans participating in the Commonwealth Fund study illustrate the range of MCO approaches to breast and cervical cancer prevention:

Comprehensive Health Services, Inc./The Wellness Plan, a staff and IPA-model HMO in Michigan serving primarily Medicaid recipients (89%), uses multiple strategies. Provider-focused strategies in the staff model include reminders, performance feedback, financial incentives, and guidelines for providing care to patients who walk into the clinic without an appointment. The plan also uses a variety of patient reminders.

Group Health Cooperative of Puget Sound, a predominantly group model model HMO, operates the Breast Cancer Screening Program. Its hallmarks are the invitation and reminder systems and a computerized data base on program participants that includes information on breast cancer risk factors and mammography usage as well as follow-up data for women with abnormal mammography results. The plan tracks use of the breast cancer screening services among female plan members and sends them reminders to receive the services according to a personalized schedule.

Harvard Pilgrim Health Care is a mixed-model HMO serving four New England states. In its group model model mode, the plan uses a reminder system for providers. The reminder system produces a health screen report that shows the status of the patient's previous screens and indicates new screenings that are due according to the plan's guidelines. HPHC also provides performance feedback and financial incentives to providers and it facilitates outreach to patients by giving providers a kit that contains information about effective ways to improve delivery of clinical prevention services. In 1997, to encourage implementation of these strategies, the plan gave providers the opportunity to compete for funds to support prevention services.

Kaiser Foundation Health Plan, Inc.—Southern California Region is a group model HMO. Its cervical screening and disease surveillance programs aim to improve screening and expedite timely follow-up by (1) working with the plan's physicians to develop screening guidelines and quality assurance indicators and (2) using an automated system to identify women, track care, and issue provider reminders.

Keystone Health Plan East, Inc. is an IPA HMO in eastern Pennsylvania. The plan is partnering with the American Cancer Society to implement and test the effectiveness of the prevention strategies in Putting Prevention Into Practice (PPIP) in a subset of their offices. PPIP is a research-based team approach that uses a kit of materials designed to improve the delivery of clinical prevention services. The kit targets the clinician, office staff, and consumer. The plan is monitoring the kit's impact on prevention services outcomes and on clinician and consumer satisfaction.

Park Nicollet Clinic is part of an integrated health care delivery system that serves Minneapolis and its suburbs. Relevant interventions include development of screening guidelines, visit planning, preventive care labels on charts, use of patient risk information, provider feedback, and an automated letter-generation system to report mammography results to patients and providers.

U.S. Healthcare is an IPA-model plan operating in 15 states. Its U.S. Healthcare Check program uses enrollment data to identify female members over 40 years old, target them with information, and (for those 40–49) conduct a risk assessment. The program generates a referral form that allows the women to access mammography directly, backed up by a reminder system for those who do not obtain the test in 60 days. Providers receive chart labels of mammography results and computer-generated information that compares their office with other providers. Performance quality on prevention services like mammography is also incorporated into the physician's compensation.

Second, health plans target providers to an even greater degree than patients. Again, by definition, the network of providers—even in a loosely configured IPA model—has some affiliation with the plan. Thus, plan strategies to prompt the physician or staff to review the patient record at each visit, to provide reminders that screenings are due, or to provide comparative performance data or even financial incentives are not easily replicated by solo practitioners or public sector clinics. A few plans target the providers' office staffs as well, intending them to be the principal actors in reviewing the prevention status of patients.

The most common patient-focused prevention strategy is screening reminders. Again, the captive audience and computerized data of HMOs permit considerable targeting. Enrollment data allow the plans to target age-eligible women. Combining enrollment data with claims and laboratory data, plans can track the periodicity of screening and pay extra attention to women who are overdue. Further, by integrating these data with information from risk assessment surveys, they can highlight issues of high-risk women. In contrast with their public counterparts, the plans tend to use less aggressive outreach. For example, none in the Commonwealth Fund study were using outreach workers or lay health workers in the community. Plans may not draw from a contiguous geographic area, making outreach a less effective strategy; but, more importantly, plans tend to believe that inreach is more cost-effective than outreach.

Despite current levels of activity, health plans at the Commonwealth symposium recognized several future challenges that present excellent opportunities for collaboration with the public sector:

- **Moving beyond the staff model.** A major challenge to all health plan efforts is the shift to IPA (independent practice association) models. Most of the exemplary programs cited are being conducted in staff or group model plans. IPAs alter many of the characteristics that make prevention attractive and easier to do in the health plan, as opposed to fee-for-service, setting. While the audience is still captive in an IPA-model HMO, the providers are working for multiple plans. No one plan may dominate their patient pool; hence they are reluctant to undertake initiatives for only some patients. Likewise, inreach has been a mainstay of the breast and cervical cancer control efforts of health plans, in part because enrollment data and the automation of medical records have made it possible to track screening periodicity without manual chart review. Because IPA models employ a dispersed network of numerous office-based providers, standardizing such a system in each office is not feasible. Also, because providers work for multiple plans, an automated system that applies to only a few of their patients is not likely to be used.

The increasing prominence of IPA models may make some plans more receptive to community-wide initiatives. Some very tentative steps have been taken in some locations to develop community partnerships of plans to address prevention issues. In time, plans may develop common systems of data collection, making the automated record feasible, or work together on community screening initiatives and, perhaps, a registry, as they do for immunization. Plans recognize that hard-to-reach women are likely to rotate in and out of plans frequently and that a community approach benefits all. In addition, the better plans tend to score about the same on most quality measures, hence working together to improve community screening rates does not destroy a competitive advantage for individual plans.

- **Reaching high-risk women.** To fill data gaps on risk and demographics, plans may use self-report surveys that are sent to women on their 40th birthday or upon entering the plan. Some plans represented at the Commonwealth symposium (recall that these were among the best) reported very high return rates for these surveys. Others, used to dealing with Medicaid populations, have had less success in terms of both return rates and accuracy of the self-reported information. It is likely that most plans proceed without these data.

OUTREACH APPROACHES

Not all plans were as critical of outreach. Mercy Health Plan, for example, is contracting with community-based organizations (CBOs) to bring in women it has identified as hard to reach. The plan pays CBOs for the mammograms and an additional amount for bringing these women into the plan. Similarly, Harvard Pilgrim Health Care (HPHC) was among the first to recognize that it had fully exploited inreach and needed to augment it with outreach methods. HPHC staff assembled a "bench marking" package for their providers based on successful approaches they identified from a literature search and discussion with other plans.

- **Reaching nonparticipating women.** Some plans that have conducted inreach for many years have found that their screening rates plateau. The issue becomes reaching the invisible consumers who do not frequently use the system. Also, plans expect (or have experienced) increases in the number of invisible consumers as they take on new populations with multiple problems and needs. Again, the enrollment data base allows them to identify these women, although transiency makes it hard to keep track of them. Many plans do not collect race and income information on their patients, and this lack may mask patterns among patients who are missed by the screening process. Plans' inreach efforts will not reach these women, yet many plan representatives were very critical of outreach strategies; based on their own studies, they believe these to be ineffective with hard-to-reach women. Some of this belief may reflect their relatively narrow definition of outreach, which is limited mainly to direct mail invitations.
- **Setting, context, and delivery.** There is considerable debate about setting, context, and delivery of breast and cervical cancer (BCC) interventions on

three fronts. First, should prevention be disease-specific or part of a more comprehensive multifaceted prevention intervention? Breast and cervical cancer control has benefited from the disease-specific approach. It is often viewed as the "jewel in the crown" disease for intervention efforts because the target women are identifiable and there are useful interventions to offer them. A more comprehensive prevention approach might be more effective, however, in making gains in overall health status.

Second, should prevention be integrated into the normal delivery system for acute care, or be a stand-alone parallel system? The issue is the burden on providers for conducting and documenting prevention activities in the short time allotted for a patient encounter. While research indicates that providers do a good job of assessment and screening in a well-care visit, they do much less during an illness visit and really don't have time to do more at that time. Some plans suggest creating prevention centers where patients would go annually for a panoply of screenings and physicals. These centers would have the time and personnel to do it right, and would be able to target interventions to increase screening rates. However, if capturing missed opportunities is the main way to increase screening rates, then isolating prevention from the acute care setting seems ill-advised. An intermediate approach is to create comprehensive women's centers that serve both acute and prevention needs. The woman is still tied to a primary care program (PCP), and still comes in for acute care, but she can also avail herself of a variety of supporting wellness and prevention activities.

Integrating Prevention and Acute Care

Harvard Pilgrim's response to both patient and provider concerns has been to introduce physician extenders who take advantage of prevention opportunities during acute care visits. While the patient is waiting to see the physician, the extender screens the file, works with the patient, and accomplishes some screens. The physician still has the primary relationship, the patient still gets to see the physician, and the extender is able to accomplish prevention activities without adding to the MD's burden or time crunch.

Third, who should provide prevention services? Most MCO providers are physicians, especially in network-model MCOs. While they may complain about lack of time to do prevention services, they may also be reluctant to delegate these services to surrogates such as physician assistants or certified nurse practitioners. And plans may fear that enrollees expect to deal directly with physicians, although Harvard Pilgrim focus groups indicated that enrollees valued the quality of the relationship more than the gender or health profession of the provider.[26]

[26]Private communication from health education staff of Harvard Pilgrim Health Care, November 1996.

A key lesson health plans have learned is that the providers must be supportive for any intervention to work. Even though a plan can accept National Cancer Institute or U.S. Prevention Services Task Force recommendations on screening, many choose to convene provider panels to review and canonize their own screening guidelines, as a way to build consciousness and ownership. Similarly, plans indicate that prevention efforts must have a champion, and that choosing the right champion (someone visible and credible with the providers) is key.

At the back end, funneling data-base information back to the providers is key, especially the names of women who have not come in for screening and how the provider's performance compares with that of others. The motivation of providers to do better increases where, as in Minnesota, the public also has access to this performance information.

Opportunities for Collaboration

While managed care has been part of the health care landscape for decades, the issue of collaboration across sectors took on new prominence with the relatively recent advent of mandatory Medicaid managed care. This section describes collaborations that are under way.

Knight conducted case studies of five current public-private collaborations (see inset, p. 22) and concluded that collaborations fall into four types: *Mandatory* collaborations are required by law or as a prerequisite for a grant. *Contractual* ones are defined and guided by a formal agreement. *Cooperative* collaborations have no external motivation or structure; the basic tenet is a shared vision and desire to attain the goal. And *community-based* collaborations are generated by the community itself and include many actors in addition to the health plan and the local health department.[27]

Macro International's research found a similar range of initiatives across the three core public health functions of assessment, policy development, and assurance.[28] In assessment, at one case-study site the local health department partners with the major teaching hospitals and the community health centers in a community health alliance that assesses community health needs and pools resources to meet them. At a Midwestern site, the state's health care reform law requires health plans to develop collaboration plans; as a result, the community needs assessment process, which for years was a local health department (LHD) function, has taken on new prominence and major collaborative efforts across sectors are under way.

In policy development, a midwestern case-study organization joined with the public sector and competing health plans to advocate tobacco legislation. And the public sector has been actively involved in violence prevention efforts originally

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[27]Knight W. *Improving the Public's Health: Collaborations Between Public Health Departments and Managed Care Organizations.* Washington, DC: Joint Council of Governmental Public Health Agencies, Work Group on Access, Assurance, and Reimbursement for Primary Care; 1996.
[28]Chapel 1996. Op. cit. (footnote 21).

CURRENT PUBLIC-PRIVATE COLLABORATIONS

In *Minnesota,* the Population Health Initiative creates a neutral forum for public and private organizations to pursue common population-based goals and define respective roles and responsibilities. The principal result has been a common planning framework for health plans and public health agencies and the creation of a center for population health that will initiate joint public-private initiatives in assessment, policy formation, research, and training.

In *Philadelphia,* the Department of Public Health and Mercy Health Plan launched a collaboration to improve immunization rates. Mercy provided a $1.3 million grant to the Department of Health to complete the immunization registry and tracking system, provide nurses to administer express-lane immunizations in district health centers, and provide public health nurses to do in-home immunizations.

In *Baltimore,* the City Department of Health entered into an agreement to provide limited services at its 10 school-based health centers for patients of Total Health Care. The centers perform early and periodic screening, diagnosis, and treatment (EPSDT) examinations and some follow-up care for Total's patients.

In *Seattle,* a National Institutes of Health (NIH) funded project has combined the efforts of the University of Washington, the Group Health Cooperative of Puget Sound, the Seattle-King County Department of Public Health, the Minority Health Coalition, and a local provider to develop and evaluate community-based health interventions for children 10–14 years old in minority communities in four related areas: interpersonal youth violence, adolescent pregnancy, sexually transmitted diseases (STDs), and substance abuse.

In *Vancouver, Washington,* a strategic planning process called "Community Choices 2010" is bringing together public and private stakeholders to design long-term programs to improve community health. It evolved from a health department strategic planning effort into an independent community partnership that involves the private sector, including local health plans. Most funding comes from the public sector, but there is active private participation in the leadership committees that are doing the community assessments and setting priorities.

organized by the case-study organization. At many sites, the LHD and the case-study organization are major participants in the local Healthier Communities initiative.[29]

In assurance activities, immunization is an area with extensive public-private collaboration. In one city, all plans and health systems had joined with the LHD, contributing funds and staff to extend the hours of immunization clinics, provide some in-home immunizations, and implement an immunization registry and tracking system. At an inner-city site, the LHD and the community asked the case-study organization to take responsibility for an immunization "blitz" of community children about to enter school. The LHD provided the vaccine, the health plan provided the person power, and CBOs did the outreach.

[29]Healthier Communities initiatives emphasize involvement of major stakeholders in definition of root causes that underlie health care issues.

A large urban health department was building partnerships for service delivery by contracting with private organizations to staff its system of primary care clinics. The private partners obtain a bricks-and-mortar network in the community, while the LHD gets stable medical expertise, a backup system of specialists, and steady rental income to support core public health activities. And most LHDs were expecting to pursue health plan subcontracts for outreach, case management, and other services with vulnerable populations. One health department had consolidated its internal, community-based, and outreach programs into a single division, while others were overhauling their accounting systems so that costs for units of service could be accurately determined.

Despite the active involvement and interest in breast and cervical cancer control by health plans, and their extensive internal efforts on behalf of their enrollees, active public-private collaboration was only beginning to get underway at the time of the study. While collaboration may be more extensive since then, private and public sectors tended to act independently, perhaps because of limited knowledge of each other's efforts or a sense that the target audiences were different. Nevertheless, current examples of collaboration may provide models for the future:

In *Maine,* recent initiatives are convening the state's health plans and other key stakeholders to define common protocols and guidelines and to allocate responsibilities in community health. The collaboration is expected to lead to agreements between plans and public and nonprofit organizations to deal with low-income populations.

In *Minnesota,* the state health department convened a managed care working group that included the major health plans in the Twin Cities area. The group has identified all current breast and cervical cancer initiatives, gaps in services, and areas for potential cooperation and collaboration. The group is in the first stages of collaborating on patient education and professional education materials. The health plans have expressed interest in working with the state health department on mobile mammography screening, expanding the state health department's current efforts to include the community clinics and vulnerable populations that are now participating in the Medicaid managed care programs of the health plans. The BCC program, working collaboratively with two health plans, recently adapted a continuous quality improvement (CQI) program developed by the plans, is pilot testing it in two community clinics and one rural clinic, and hopes to expand the effort statewide. In addition, most of the major health plans have designated a staff member with responsibility for breast health, and the Medical Director of the state's BCC program serves on the breast health advisory committees of several plans.

Oregon has implemented a variety of managed care-related activities. The Oregon Health Division conducted surveys of 19 MCOs concerning the health plans' infrastructure to support and ensure delivery of preventive services. They also involved MCOs from the start in developing consensus guidelines. Oregon has found that data initiatives are among the first and most effective ones to pursue with health plans. The state is working with the plans to help design systems that can monitor compliance with diabetes guidelines. This model has potential applications to other areas such as breast and cervical cancer. Discussions are also under way concerning health plan use of an instrument similar to the Behavioral Risk Factor Surveillance System (BRFSS) instrument. Oregon conducted a study of newly enrolled Medicaid women to assess their experience with preventive services such as mammography prior to and after plan enrollment. They will work with the MCOs to address any problem identified. This effort has proven an effective way to build relationships with the MCOs and to educate their members about screening services. The Health Division's Health Promotion and Chronic Disease Prevention program staff also serve on the quality assurance committees of several health plans.

In *South Carolina,* the BCC program has expanded its continuing education for providers and health professionals to include staff of one of the major MCOs, Companion Health Care (CHC). The program's regional service coordinators provide on-site professional education to CHC's provider sites serving more than 400 enrollees. The collaboration built on an existing curriculum that CHC had been using effectively. Plan and BCC program staff worked together to revise the curriculum and to get authorization to offer continuing medical education credits. Through this collaboration, BCC gets access to an important provider network, and CHC is able to extend the training to more providers than its in-house program was able to serve.

In *Tennessee,* an active collaboration among a local health plan, Meharry Medical School, and the state and local health departments is training outreach workers who are then placed in community clinics as advocates for low-income women. In this role, the outreach workers also encourage screening. The workers are selected from the enrolled population of the health plan. The nursing school at Meharry provides 12 weeks of training, which results in certification as a nursing assistant and paid positions on the staff of the MCOs.

In *Washington,* a special CDC-funded initiative partners a prominent health plan (Group Health Cooperative of Puget Sound) and the state health department to offer augmented service models for low-income and vulnerable women. The health plan will test several models to see which works best to bring women in for screening and keep them in continuous care. The MCO had extensive inreach

activities and a strong reminder system. The health department was supplementing these with their own expertise in outreach and formative research, conducting a series of focus groups with low-income women to explore their experiences in managed care plans.

In addition to these examples of collaborations between grantees and health plans, the Fox Chase Cancer Center in *Connecticut* provides a good example of collaboration between nonprofits and health plans. A key component of the program was an innovative referral system that used the HMO's administrative capacity to target women aged 50 to 75 years and guide them through a series of stepped interventions to promote compliance with screening guidelines. Other interventions targeted primary care physicians and radiologists.

Collaboration Barriers and Facilitators

What can be done to foster more collaboration? The choice health plans make about collaboration—whether or not to collaborate with the public sector or with others—is influenced by factors like the number of clients affected, the saliency of the area for the MCO, their background in providing this or similar services, and their background in dealing with these or similar clients. In the end, plans are making a classic "make-buy" decision. Do we do it ourselves or hire someone to do it for us? However, the decision is not based on the economics of service delivery alone. Factors such as goodwill, community benefit, and image also play a role in the decision; a plan may select an option that is more costly in immediate terms because it builds community position in the long run.

Orbovich found that common barriers to collaboration between the private sector and either the public or the nonprofit sector included:

- **Cultural differences and organizational mindsets.** Community providers take a public health approach; plans may not see the benefit of including support and enabling services; the two may not share a common definition of prevention and primary care.
- **Administrative systems.** Nonprofit and public organizations are often afflicted with weak administrative structures, minimal knowledge of capitation financing, and inadequate information and reporting systems relative to what managed care deems necessary. They may also lack the capital to strengthen these systems.
- **Financial arrangements and incentives.** Most public and nonprofit organizations cannot accurately price services or specify costs. On the other hand, health plans' actuarial models may not be able to incorporate adjustments for the multiple complications of attending to needs of low-income populations or providing comprehensive, public-health-oriented service models.

Based on its own research, Macro International concluded that when health plans do collaborate, they have a variety of potential partners other than local health departments (LHDs). Often the local health department is left out for the following reasons: (1) LHDs often had provided an oversight and reporting in the past, and most assumed they would do quality assurance in the future. Plans want more

control in the future; they are not likely to entrust new data initiatives to those to whom they formerly reported. (2) LHDs are often mired in bureaucracy that makes it hard to hire and fire, obtain equipment, and perform functions flexibly. CBOs and community health centers (CHC) are seen as more flexible and more accountable to them in contracting relationships. (3) LHDs serve narrow geographic areas, while health systems and health plans may cross county, metropolitan, and even state boundaries. While community health centers (CHCs) and CBOs also have narrow catchment areas, it is easier for them to form alliances to serve a larger area.[32] The Commonwealth Fund symposium discussed earlier shed light on why there are so few public-private collaborations in breast and cervical cancer, despite the level of health plan interest in this topic and the sometimes significant level of investment in internal prevention efforts with enrollees:

- **Lack of knowledge.** While no plan representatives seemed surprised that CDC funds a network of grantees, few seemed to know much about the grantees, their responsibilities, or their services.
- **Inadequate data.** Quality assurance researchers want better data on effectiveness than the public sector is able to provide. One plan's representative commented that their own standards for data quality were higher than the standards used in compiling the CDC data. (Ironically, with the exception of the best plans, it does not appear that the private side has much better data on the effectiveness of interventions.)
- **Narrow focus.** A plan representative indicated that the public programs were perceived as good on identification and outreach, but not on follow-up and treatment. Indeed, this is the reason for the current collaboration. Since plans are primarily clinical caregivers, they may give more credibility to organizations like themselves.
- **Concerns about outreach.** Many health plans have had bad experiences with outreach initiatives. They may see public sector efforts as primarily outreach-focused and unsupported by evidence of effectiveness. Also, they may be unaware of public sector efforts in inreach or public education.

[32]Chapel 1996. Op. cit. (footnote 21).

FACTORS THAT DISCOURAGE COLLABORATION

Orbovich found that health plan interest in collaboration varied with market penetration of managed care, the prevalence of inner-city and rural populations, the state waiver status and local regulatory environment, the degree of competition and the historical relationship among key potential partners, and the degree to which the partner is willing to assume risk.[30]

Halverson et al. found that less than half of the local health departments in jurisdictions served by managed care plans maintain any formal or informal relationship with a plan; they conclude that the blame lies with relatively low penetration levels of managed care, location of the MCO corporate office outside the jurisdiction, low levels of Medicaid beneficiary enrollment in managed care, and local health department visibility as an efficient and effective provider.[31]

[30]Orbovich 1996. Op. cit. (footnote 13).

[31]Halverson PK, Mays GP, Schenck SE, et al. Organizational Linkages in Public Health: Interactions Between Local Health Departments and Other Health Care Providers. (Under review)

Next Steps to Foster Collaboration

Knight identified several actions that would make collaboration with the public sector more effective: promoting opportunities for interaction among public and private health care providers; conducting an LHD organizational assessment to document and advance the status of the knowledge and skills necessary to be part of collaborations; consolidating individual organization efforts into a master plan for technical assistance and training in collaboration with MCOs; establishing a national clearinghouse; ensuring adequate funding for community-based health services; and establishing state-level protocols and guidelines for minimum levels of care for vulnerable populations as well as a prototype management information system (MIS) to monitor the quality of health care services to vulnerable populations.[33]

Orbovich's respondents identified similar factors for successful collaboration:

- Plan and CBOs willing to learn from each other.
- Plan and CBOs create a stable liaison relationship with close, regular consultation.
- Problem solving teams focus on issues.
- Plans share provider feedback with the CBOs.
- Plans arrange provider technical assistance for CBOs on MIS and financing.
- Plans involved in advocacy on reimbursement and other financial issues.
- Plans provide continuing education on clinical and administrative issues.[34]

Individual overtures of health plans and NBCCEDP grantees are likely to be productive; but the receptiveness of private sector organizations to collaboration can be enhanced if BCC programs and the public agencies that house them harness market forces and other levers to their advantage:

- **Mandates.** Although the issue of mandated benefits is controversial, some states and even health plans insist that generating significant private activity in prevention, especially communitywide activity, requires mandating it as

[33]Knight 1996. Op. cit. (footnote 27).
[34]Orbovich 1996. Op. cit. (footnote 13).

MANDATES FOR COLLABORATION

Massachusetts' guidelines for health plans coincided with plan and health system interest in vertical integration; the external mandates were the extra incentive to form partnerships between providers and community entities. Minnesota's health reform legislation requires a collaboration plan as well; it has brought plans and county health departments (who already conducted legislatively-mandated assessments of community health needs) into closer contact.

part of all insurance contracts. And, in fact, many plans want to undertake more activity, but fear that, absent a mandate, the costs would have an adverse impact on their price competitiveness. State health care reform legislation or other local regulations can require health plan interactions with community organizations and the health department as well as financial support for community activities.

- **Government contracts.** Even without explicit mandates, state and local governments have considerable ability to influence the types of services in managed care contracts through their power as purchasers. Both the state public employees' health insurance contract and the state's Medicaid managed care contract offer opportunities to advance private participation in essential public health services. Because the number of enrollees covered under these contracts is great, the plans serving them are likely to extend the covered prevention services to other enrollees (a phenomenon known as the "spillover effect").

- **Community benefit requirements.** Nonprofit hospitals are under increasing scrutiny by the Internal Revenue Service and community activists to demonstrate their contribution to the community in ways other than charity care. And some states are extending community benefit requirements to all nonprofit health care providers, setting specific guidelines for community participation by not-for-profit health care organizations.

In Massachusetts, such guidelines specify the creation of community service plans in close consultation with the community and set some priority areas for community involvement.[35] More to the point, Massachusetts' Attorney General has set specific community investment guidelines as a condition of merger for several health care organizations.[36] Related to this, California and other states are confronting the issue of community benefit head-on in dealing with the conversion of not-for-profit Blue Cross/Blue Shield plans to for-profit status.[37]

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[35]See *State Health Watch* 1995; 2(7). New similar guidelines have been developed with the state's for-profit and not-for-profit HMOs. They recommend that plans target the working poor, victims of domestic violence, the elderly, minorities, and the disabled in their community service efforts. HMOs are also asked to make an annual report on the scope and purpose of their programs. (See *State Health Watch* 1996; 3[3].)

[36]As a condition of approval of the merger with Pilgrim Health Care, the merged entity must increase its contribution to the Harvard Community Health Plan Foundation by $3.5 million over the next three years to support community activities in substance use, prenatal care, and violence.

[37]See, for example, Bailey AL. Blue Cross conversion plan creates suspicion. *The Chronicle of Philanthropy* 1994.

Strategies for Programs

Clearly, managed care offers both opportunities and threats. Maximizing the positive and minimizing the negative impacts is often a function of having the foresight to think through the issues in advance. There are important roles to be filled by cancer prevention and control programs even if all service delivery is successfully privatized. Indeed, many public agencies are anxious to mainstream service delivery so that more resources can be devoted to assessment, policy development, and quality assurance.

NBCCEDP grantees and their host organizations should be pursuing the following strategies right now:

- **Establish key MCO links.** The staff of interest, who will vary with what is to be accomplished, include:

  Medical director. This is the key contact for promoting clinical protocols, identifying professional training needs, and encouraging provider reporting.

  Public health liaison. Several state Medicaid contracts require MCOs to designate a staff member to coordinate how the MCO will work with the public sector. This is an important point of entry for discussing collaboration on service delivery.

  Foundation. Many HMOs (particularly the nonprofit staff or group model ones) have foundations that devote resources to research and development. Often health promotion and prevention effectiveness fall within the scope of the foundation's interest. Even if funds are not provided, the foundation can help establish links for collaboration between the public sector and the MCO.

- **Examine distinctive competencies.** Grant programs should examine what they do best and where they need support. The areas of excellence are the ones to emphasize in collaboration discussions with health plans.

- **Target areas in which health plans are most interested.** While the needs of plans are as varied as the needs of grantees, Macro International's research found some patterns in health plans' need for technical assistance that the public sector might provide:

Prevention guidelines. Private organizations have little knowledge of prevention and what knowledge they have tends to view prevention as a cost-saving mechanism. Better information on what works and under what conditions is greatly needed and valued.

Behavior-change models. Similarly, many private organizations pursuing public health agendas are dealing with vulnerable populations and thorny behavioral issues that they have been able to avoid in the past. They need and value better understanding of effective incentives to promote healthy, adherent behavior.

Neighborhood coalitions. Many case-study organizations were doing a credible job in dealing with low-income neighborhoods, in part because the community-benefits staff had experience and a network on which the organization could draw. However, all were having problems getting community coalitions up and running, maintaining the involvement of community members, and delineating an appropriate role that was both productive for them and empowering for the community. Help with this is much desired.

Data for management decisions. There is little epidemiological expertise at the programmatic level in these case-study organizations. Yet, often, this is where the first public health activities emerge. The organizations need help in understanding how to define indicators, collect the data, and interpret the data in ways that have implications for management decisions. Some are making fitful starts in this direction, but all recognize they need more help.

- **Pay attention to costs.** While few public agencies can determine service unit costs, many are modifying their accounting systems to do this. It is an essential step if grant programs wish to move beyond community-wide collaborations or informal partnerships to formal subcontracts. Health plans need to be assured that costs are predictable and accurate. Grant programs need to be assured that negotiated reimbursements are sufficient to cover the true cost of services.
- **Pay attention to evaluation.** Most health plans want to undertake prevention but have limited resources to do so; and, as indicated earlier, they may be suspicious of the outreach approaches that have been the mainstay of public efforts. Grant programs need to spend time and resources documenting the effectiveness of their efforts. While this need not require extensive controlled scientific studies, it does demand more than the anecdotal evidence currently available for many initiatives.

In addition, there are several steps that are probably beyond the charge of the individual NBCCEDP grantee but should be considered by the state, territorial, and tribal health departments within which these programs fall:

- **Include relevant quality assurance indicators.** Almost all Medicaid managed care programs include a limited set of "report card" indicators. Many states have used as their starting point the list of indicators developed by the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS). Become familiar with the indicators your state will use and lobby aggressively to include some relevant to your program. MCOs will pay attention first to those services on which their performance is measured.
- **Ensure the MCO contract is explicit about services.** MCOs are primarily medical providers. They may not know to take on outreach and case management functions unless instructed. They almost certainly will not unless the funds to do so are in their capitation. Know what the expectations are and make sure these are communicated.
- **Specify reporting requirements in the contract.** This is an essential way to build a surveillance database, particularly for conditions in which reporting is not required by law. Again, MCOs will pay attention first to data they are required to give. They will also encourage their providers (in IPA models) and labs to cooperate.
- **Make reporting and documentation as easy as possible.** In return for requiring reporting, work with MCOs to create an electronic interface or supply relevant software. One state-led program assumes all reporting and documentation responsibilities for any provider that uses the public laboratories.
- **Work with professional associations and others to develop consensus.** If services have been provided primarily by the public sector *and* there is disagreement about treatment approaches, it is essential that some entity convene all interested parties and resolve issues prior to privatization.

In short, managed care is here to stay. For the Medicaid and Medicare populations, full-risk capitated models will become more common in the near future, and may be extended to uninsured and underinsured women as soon as the pace of health care reform accelerates.

These models challenge the traditional roles of NBCCEDP programs and, indeed, all publicly-funded programs that address disease control and early detection. They will require grantees to examine their traditional roles, forge new partnerships across sectors, and consider elevating roles such as community assessment and coalition building that may have taken a back seat to service delivery and quality assurance. Grantees that successfully make this transition may find it easier, not harder, to meet the demands of the NBCCEDP charge as energized private sector stakeholders join public and advocacy agencies in a community approach to outreach, public education, guideline development, and follow-up with high-risk and vulnerable women.

Appendix: Glossary

Capitation—A set amount of money received or paid out; it is based on membership rather than on services delivered and usually is expressed in units of per member per month. May be varied by such factors as age and sex of the enrolled member.

Case management—Also referred to as "large case management." A method of managing the provision of health care to members with catastrophic or high cost medical conditions. The goal is to coordinate the care so as to improve both continuity and quality of care as well as to lower costs.

Closed panel—A managed care plan that contracts with physicians on an exclusive basis for services and does not allow those physicians to see patients from another managed care organization. Examples are staff and group model HMOs.

Coinsurance—A provision in a member's coverage that limits the amount of coverage by the plan to a certain percentage, commonly 80%. Any additional costs are paid by the member out of pocket.

Coordinated care—The federal government's term for managed care, presumably a "kinder and gentler" way of saying it.

Copayment—That portion of a claim or medical expense that a member must pay out of pocket. Usually a fixed amount, such as $5 in many HMOs.

Deductible—That portion of a subscriber's health care expense that must be paid out of pocket before any insurance coverage applies, commonly $100 to $300.

Direct contract model—A managed care health plan that contracts directly with private practice physicians in the community, rather than through an intermediary such as an independent practice association or a medical group.

DRG—Diagnosis-related group. A statistical system of classifying any inpatient stay into groups for purposes of payment. Form of reimbursement that the HCFA uses to pay hospitals for Medicare recipients.

EPO—Exclusive provider organization. Similar to an HMO; often uses primary physicians as gatekeepers, often capitates providers, has a limited provider panel, and uses an authorization system. The member must remain within the network to receive benefits. Main difference is that EPOs are generally regulated under insurance statutes. Not allowed in many states.

Full-risk plan—The state Medicaid agency contracts with a plan, such as an HMO, to provide Medicaid enrollees with comprehensive care. The plan receives a capitation payment for each enrollee. The capitation payment covers a specified group of services and is paid to the plan regardless of whether those services are used.

Gatekeeper—An informal term that refers to a primary-care-case-management-model health plan. Care must be authorized by primary care physicians, except for true emergencies.

Group model—An HMO that contracts with a medical group for the provision of health care services. Close relationship between the group and the HMO; a form of closed panel health plan.

IPA—Independent practice association. An organization that has a contract with a managed care plan to deliver services in return for a single capitation rate. The IPA in turn contracts with individual providers to provide the services either on a capitation or fee-for-service basis.

Limited-risk-plan—The state Medicaid agency contracts directly with providers on a capitated basis for a subset of services. The Medicaid agency also pays providers for other, noncapitated services on a fee-for-service basis.

Managed health care—A system of health care delivery that tries to manage the cost of health care, the quality of health care, and access to care. Common denominators include a panel of contracted providers, limitations on benefits to subscribers who use noncontracted providers, and a structured authorization system. Managed health care manifests itself in a spectrum of plans or systems, ranging from indemnity, preferred provider organizations (PPOs), point-of-service (POS), open-panel HMOs, and closed-panel HMOs.

MCO—Managed care organization. A generic term applied to a managed care plan. Some prefer it to the term HMO because it encompasses plans that do not conform exactly to the strict definition of an HMO.

NCQA—National Committee for Quality Assurance. A not-for-profit organization that performs quality-oriented accreditation review on HMOs and similar types of managed care plans.

Network model—A health plan that contracts with multiple physician groups to deliver health care to members. Generally limited to large single- or multi-specialty groups.

Open panel—A managed care plan that contracts, either directly or indirectly, with private physicians to deliver care in their own offices. Examples include a direct contract HMO and an IPA.

Point of service—A plan where members do not have to choose how to receive services until they need them. The most common type of POS plan enrolls each member in both an HMO (or HMO-like) system and an indemnity plan.

PPO—Preferred provider organization. A plan that contracts with independent providers at a discount for services. The panel of providers is limited in size and usually has some type of utilization review system associated with it.

Prepaid health plan (PHP)—Falling between the full-risk plan and the primary-care-case-management plan (PCCM), PHPs either contract on a prepaid, capitated risk basis to provide services that are not risk-comprehensive services, or contract on a nonrisk basis. Some PHPs meet the definition of HMOs, but are treated as PHPs through special statutory exemption.

Primary care case management (PCCM) plan—The state Medicaid agency contracts directly with primary care providers to act as "gatekeepers," approving and monitoring all covered services for the patient. For this case management service, the primary care providers are paid a per-patient, per-month case management fee (usually around $3 to $5); in addition, the providers are reimbursed by the state on a fee-for-service basis for all services provided.

Staff model—An HMO that employs providers directly, with the providers seeing members in the HMO's own facilities. A form of closed-panel HMO.

Waivers—States must obtain waivers of current federal Medicaid law (i.e., the Social Security Act) from the Health Care Financing Administration (HCFA) to enroll their Medicaid population in managed care plans. The two types of waivers that may be obtained for this purpose are Section 1915(b), or freedom-of-choice waivers, and SECTION 1115, research and demonstration waivers.