THE HENRY J. KAISER FAMILY FOUNDATION

Public Health in a Changing Health Care System:

Linkages Between Public Health Agencies and Managed Care Organizations In the Treatment and Prevention of Sexually Transmitted Diseases

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Linkages Between Public Health Agencies and Managed Care Organizations in the Treatment and Prevention of Sexually Transmitted Diseases

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The views expressed in this report are those of the authors and do not necessarily reflect those of the Foundation.

Table of Contents

Executive Summary iii
Introduction 1
  Key Issues 1
  Background of Study 2
Study Methodology 3
Findings 3
  The Involvement of State Medicaid Agencies in the Establishment of MOUs 3
  Content Analysis of the MOUs 4
  The Creation, Promulgation, and Implementation of MOUs 7
  Allocation of Treatment Decision-Making and Data Authority 9
  Compensation for Services 11
  Data and Case Reporting 12
  Dissemination of Standards of Care 13
Discussion 13
  Conclusions 14
  Opportunities and Challenges 15

Figures and Tables

Figure 1:
Potential Dynamics of Power-Sharing in Public Health/MCO Collaborations 9
Figure 2:
Spectrum of Medical Treatment Decision Making Powers 10
Table 1:
A Typology of Memoranda of Understanding (MOUs) Between Public Health Agencies and Medicaid-Serving Managed Care Organizations 16
Table 2:
Services Relating to Sexually Transmitted Diseases in Agreements Between Medicaid-Serving Managed Care Organizations and Public Health Agencies—Selected Sites 22

Executive Summary

One of the most important public policy issues raised by the transition to managed care is its effect on public health policy and practice. Conceptually at least, managed care represents a tremendous advance for public health. This is because the central feature of managed care from a structural viewpoint—its establishment of organized systems of prepaid health care for thousands of members—signifies a marked departure from the disjointed fee-for-service system. Both managed care organizations (MCOs) and public health agencies share population-wide concerns and are oriented to the provision of services to large groups of individuals rather than individual patients. At least in theory, managed care and public health agencies share an interest in preventive interventions that both improve the health of the population they serve and are consistent with the performance of core public health functions, such as community health surveillance and health care assurance.

The issue of shared responsibility between public health agencies and MCOs is embodied in the context of evolving relationships between them, as exemplified by the written agreements—often known as Memoranda of Understanding (MOUs)—that serve to codify the respective roles and responsibilities of each entity. Given the paramount importance of delivering both individual and population-based services for the prevention and control of sexually transmitted diseases (STDs), this study focuses on the evolving relationships between MCOs and public health agencies through the intersecting lenses of epidemiology and health services delivery and financing. By utilizing a content analysis of several MOUs supplemented by on-site interviews, this study attempts to answer the following questions:

1. To what extent do the MOUs address the utilization of local public health agencies as network providers for the delivery of managed care contract services that are relevant to the testing, treatment, and control of STDs?

2. To what extent do the MOUs address the role of public health in community-wide protection against the spread of STDs? Specifically, do the MOUs address the role of public health in establishing the practice standards to which MCOs and their network providers will adhere in the assessment, diagnosis, and treatment of STDs?

3. To what extent do the MOUs address issues of access to relevant data by public health agencies for the measurement and monitoring of community health status or the adequacy of treatment? Are other essential activities such as partner notification addressed within the MOUs?

Because the prevention and treatment of STDs represents such an important area of public health, the Kaiser Family Foundation provided support for the Center for Health Services Research and Policy (CHSRP) of The George Washington University Medical Center's School of Public Health and Health Services to conduct this study of the evolving relationships between MCOs and public health agencies.

The study uses two different sources of information in an attempt to measure the evolving structural underpinnings of the managed care/public health relationship. The first is a content analysis of agreements between MCOs and public health agencies, which were collected in two waves between 1997 and 1998. A second source of data is on-site interviews with the staff of local public health agencies, also conducted between 1997-1998. State and local public health and state Medicaid agency officials were interviewed in 10 communities. In most communities, MCO officials also were interviewed.

The major findings of this study include:

- **MOUs as managed care network provider agreements:** An examination of the MOU documents reveals two clear limitations. First, as a general matter they are structured to function as straightforward managed care network provider agreements rather than as a comprehensive framework for the many dimensions of the public health/managed care relationship. Second, and perhaps more relevant and surprising, the agreements do not appear to reflect any of the special considerations that might be expected to arise when local public health agencies participate in managed care networks.

- **MOUs as reflective of managed care rather than public health imperatives:** The MOU analysis shows that the documents are structured to function much like any traditional provider network service agreement. Thus, they tend to address only in very limited ways (and frequently not at all) those aspects of the public health/managed care relationship that pertain to the ability of public health agencies to carry out all aspects of their missions.

- **Similarities and differences among MOUs:** Nearly all the MOUs reflected the public health agencies' view of the importance of furnishing plan members with certain personal health services that are covered by the MCO contract and essential to public health (e.g., family planning, immunizations, screening and treatment for STDs and HIV, treatment of tuberculosis). Yet, the MOUs vary greatly in the range and scope of services they cover—a fact which is driven probably as much by the uniqueness of local health agencies as the purchasing expectations of the MCOs.

- **Results from on-site interviews:** State and local health agency officials reported limited involvement in the creation of the model MOU templates, which were created primarily by state Medicaid agency officials. The MOUs, both on paper and in practice, cede activities to the MCOs, including treatment decision-making, data reporting, and compensation for services rendered by the public health agencies. It is often the practice that MCOs engage in dissemination of standards of care to their contracted providers in areas such as obstetrics, acute care, asthma, diabetes, etc. However, the MOUs did not require the MCOs to do this for communicable diseases, such as STDs or HIV (although there were efforts in this regard for tuberculosis and childhood immunizations).

Based on these findings, this study arrives at the following conclusions:

- The fact that the MOU templates are not confined to specific group sponsors supports the conclusion that both public health agencies and MCOs view their relationship as systemic, rather than confined to certain portions of the managed care population.

- The MOUs, which were developed either by health agencies or by Medicaid agencies in some level of collaboration with health agencies, demonstrate the limited understanding on the part of public health officials regarding the potential effects of managed care on the full spectrum of public health policy and practice.

- To a remarkable degree, public health agencies view their role as secondary to that of purchasers, rather than as primary to the protection of public health.

- The relatively limited attention paid to STDs in the MOUs suggests that public health agencies place less emphasis on the control and treatment of STDs than is the case with other types of communicable disease.

- The interviews with public health officials suggested that the presence of alternative sources of funding to support STD treatment and control may have diminished their interest in addressing the confidentiality and administrative barriers to managed care compensation for covered services. Understandably, public health agencies prefer to depend on alternative sources of funding to cover the cost of confidential testing and treatment, rather than risk the loss of patients over the issue of disclosure. This study underscores the importance of sustained funding for such activities.

The widespread adoption of managed care creates major opportunities for public health interventions; at the same time, it raises new challenges. For the issues raised by this study to be properly addressed, public health agencies need to reconsider their basic orientation to managed care. Managed care affects more than the direct health care service obligations that devolve from the master agreement. Numerous aspects of managed care raise specific issues for public health agencies. In particular, these are the need to reexamine and update notifiable disease, privacy, and confidentiality laws, and the need to consider new policies in the area of authority over treatment decision-making in cases involving communicable disease.

As public and private managed care purchasers become aware of managed care's potential impact on public health, they may be willing to make certain public health-related practices a basic contractual duty on the part of the companies with whom they do business. At the same time, the ultimate responsibility lies with public health agencies themselves to ensure that both public and private purchasers understand managed care's potential public health effects and to develop a comprehensive approach for the modernization of public health policy.

Introduction

One of the most important public policy issues raised by the transition to managed care is its effect on public health policy and practice. Conceptually at least, managed care represents a tremendous advance for public health. This is because the central feature of managed care from a structural viewpoint—its establishment of organized systems of prepaid health care for thousands of members—signifies a marked departure from the disjointed fee-for-service system. Both managed care organizations (MCOs) and public health agencies share population-wide concerns and are oriented to the provision of services to large groups of individuals rather than individual patients.[1] At least in theory, managed care and public health share an interest in preventive interventions that both improve the health of the population they serve and are consistent with the performance of core public health functions of community health surveillance and health care assurance.[2]

At the same time, managed care has the potential to affect public health agencies in unexpected ways that conceivably could reduce, rather than enhance, the tools available to the agencies for maintaining community-wide health. In no area does the potential for managed care to diminish, rather than strengthen, public health carry more significance than in the prevention, treatment, and control of sexually transmitted diseases (STDs), as well as other communicable diseases. In many communities, STD rates are highly elevated, and new forms of old diseases are an emerging cause of public health concern.[3]

Since the mandate of public health is the entire community, understanding the effects of both publicly and privately sponsored managed care on public health practice and policy is essential. At the same time, because of the historic and important intersections between Medicaid and public health, issues arising from Medicaid's transformation to managed care take on particular interest. Traditionally, Medicaid has played a significant role in financing the health care and Medicaid-related administrative operations of public health agencies. Public health agencies, in turn, have played an extremely important role in the delivery of personal health services to low-income people generally, and Medicaid beneficiaries in particular.

Key Issues

In the context of the control, treatment, and prevention of STDs, three basic and separate issues related to the intersection of managed care and public health warrant consideration. The first issue is the consequence of managed care on the delivery of STD prevention, testing, and treatment services by local public health agencies. The second issue is the effect of managed care on the ability of public health agencies to exercise their historic police powers to control the spread of STDs through the use of practice guidelines and treatment interventions. The third issue concerns the impact of managed care on the community-wide surveillance activities of public health agencies as well as other public health activities, such as partner notification, that depend on access to data.

All three of these issues are embodied in the context of relationships between MCOs and public health agencies, as exemplified by the written agreements—often known as Memoranda of Understanding (MOUs)—that serve to codify the respective roles and responsibilities of each entity. By utilizing a content analysis of several MOUs supplemented by on-site interviews, this study attempts to answer the following questions:

1. To what extent do the MOUs address the utilization of local public health agencies as network providers for the delivery of managed care contract services that are relevant to the testing, treatment, and control of STDs? Numerous services that are typically included in an MCO service agreement (e.g., professional medical services, laboratory tests, prescribed drugs) relate directly to the care of people with or at risk for STDs.[4] Public health agencies in many communities represent a central source of confidential testing and treatment services; many traditionally have depended to a significant degree on third party financing, particularly Medicaid, to help support their practices.

2. To what extent do the MOUs address the role of public health in community-wide protection against the spread of STDs? Specifically, do the MOUs address the role of public health in establishing the practice standards to which MCOs and their network providers will adhere in the assessment, diagnosis, and treatment of STDs? Similarly, do the agreements address issues of payment for mandatory treatment orders, where the treatment involves the provision of services that are covered by a managed care service agreement?

3. To what extent do the MOUs address issues of access to relevant data by public health agencies for the measurement and monitoring of community health status or the adequacy of treatment? Do the MOUs address how public health agencies access data to carry out such other essential activities as partner notification? Specifically, must MCOs provide health agencies with data from laboratory test results, pharmaceutical data, general data relevant to the performance of network providers in the area of STD prevention, treatment and management, or data specific to the treatment of infected individuals?

Background of Study

Because the prevention and treatment of STDs represents a critically important area of public health, the Kaiser Family Foundation provided support for the Center for Health Services Research and Policy (CHSRP) of The George Washington University Medical Center's School of Public Health and Health Services to conduct this study of evolving relationships between managed care organizations and public health agencies.[5] The study complements a larger, multi-year initiative supported by the Centers for Disease Control and Prevention. The overall goals of the CDC initiative are to measure and understand the implications of a changing health care system for public health policy

and practice, and to design and disseminate tools aimed at forging a stronger relationship between managed care and public health.

Study Methodology

This study uses two different sources of information in an attempt to measure the evolving structural underpinnings of the relationship between MCOs and public health agencies. The first is agreements between MCOs and public health agencies, collected in two waves between 1997 and 1998. Some of the agreements that were examined were "live": they were signed and in effect at the time that the materials were examined. Others were "model" agreements developed by (or for) public health agencies for use in potential negotiations with MCOs. In some cases, these models were developed by Medicaid agencies in an effort to encourage (and in a few cases, actually require) collaboration among managed care contractors and local public health agencies.

In many states, these agreements are termed "Memoranda of Understanding" (MOUs). Because this term appears to be used relatively widely, it is adopted here in order to describe the collection of self-generated and Medicaid agency-generated documents that were examined. It is important to note that these documents do not relate only to STDs; they also apply to certain other conditions that are typically of concern to the agencies, such as maternal and child health, tuberculosis, and childhood immunizations. At the same time, because the MOUs would govern the interaction between MCOs and public health agencies on STD-related public health policy and practice, they are directly relevant.

A second source of data is on-site interviews with the staff of local public health agencies, also conducted between 1997-1998. State and local public health and state Medicaid agency officials were interviewed in 10 communities.[6] In most communities, MCO officials also were interviewed. The purpose of the interviews was to probe beyond the MOUs to examine more fully the nature of the relationship between managed care and public health.

Findings

The Involvement of State Medicaid Agencies in the Establishment of MOUs

As noted, at the time of the study, several state Medicaid agencies had identified collaborations between MCOs and public health agencies—to at least some degree—as either a required or desirable practice by their MCO contractors. Two of the study states (California and Oregon) required participating MCOs to develop MOUs with local health agencies in their service areas as a condition of award of a Medicaid managed care contract. The other states typically encouraged the development of such relationships; for example, both Michigan and Ohio awarded additional points in the evaluation of contract proposals to potential contractors that were able to demonstrate

that such agreements with local health agencies were, or would be, established. State health and Medicaid agencies in New York, Michigan, California, and Oregon developed model agreements and collaboration matrices for use as guidelines by local agencies in drafting their MOUs. With the exception of Minnesota,[7] MOU template instruments were in different stages of development at the time of the site visits, ranging from just signed to fully operational.

It is important to note that while the templates were developed by Medicaid agencies, their design (i.e., the topical areas they covered) were sufficiently generic to permit a health agency to use the same document as a template for guiding negotiations with any MCO regarding any sponsored enrollee group. For example, a Medicaid agency might have developed an MOU template for its own contractors to follow. If one of the Medicaid contractors also sells its products to 18 individual private sponsors and the state employee benefit plan, there is nothing in the MOU template that would prevent the entity and the local health agency from applying its provisions to all individuals enrolled with the entity, not just its Medicaid-sponsored members.[8]

Content Analysis of the MOUs

Table 1 on page 16 presents the results of the analysis of the MOUs and other written agreements developed between public health agencies and MCOs that were provided by the study sites or the state agencies. To conduct this analysis, the team of lawyers who carry out CHSRP's various managed care contract analysis projects developed an instrument that would allow for the capture of data from each MOU and then analyzed each document against the instrument. A cell in Table 1 contains an "X" if the instrument makes *any* written mention of the specified topic. While this table does not illustrate differences in scope and content of the relevant language, the presence of *any* language related to a particular topic is indicative of some level of awareness on the part of the people who developed the MOU of its relevance.

The MOUs share certain common characteristics, particularly in the case of the California documents, where the state prepared a model document for use by local public health agencies. Both the model and actual MOUs are highly instructive. As written, law-related instruments, the MOUs reflect how public health and Medicaid agencies conceive of their relationship with MCOs. Thus, the documents are important as a means of identifying the issues that Medicaid and public health agencies believe must be addressed in the evolving relationship between managed care and public health.

MOUs as managed care network provider agreements: An examination of the MOU documents reveals two clear limitations. First, as a general matter they are structured to function as straightforward managed care network provider agreements[9] rather than as a comprehensive framework for the many dimensions of the public health/managed care relationship. This is not surprising perhaps, since the relationship at issue is the

one between managed care and local public health agencies as health care providers rather than managed care and a state public health authority in its oversight and police powers capacity.

Second, and perhaps more relevant and surprising, the agreements do not appear to reflect any of the special considerations that might be expected to arise when local public health agencies participate in managed care networks. What makes the absence of special consideration for such issues surprising is that the documents in question were drafted by public agencies rather than managed care companies. Whereas a managed care company might understandably overlook matters with which it has only limited familiarity in creating such a template, a public agency would presumably be in a position to understand the implications of managed care for its own policies and practices. Thus, the public agency could be expected to attempt to adjust the framework to take such matters into account.

As traditional provider network agreements, the MOUs are designed to function like other service agreements between an MCO and its network providers. That is, they are structured to ensure that public health agencies, like other network providers, support MCOs in the performance of their own contractual obligations to their group sponsors. They are not meant to function as templates for ensuring that managed care systems act in ways that are consistent with public health policy and practice. Indeed, in certain respects the agreements appear to create the potential for direct conflict with certain public health policies. Most of the MOU provisions relate to the business relationship created by managed care, such as clauses relating to the indemnification of the parties in the event of a liability ruling, severability, contract terms, scope of covered services, dispute resolution procedures, and the timing, manner, and nature of payments that the MCO must make to the health agency. These issues are all central to any network provider agreement; however, they are only one aspect of the relationship that managed care might be expected to maintain with public health agencies.

MOUs as applicable to all of an MCO's managed care enrollees: As noted, the MOU template, whether developed by a Medicaid agency, a state public health agency, or a local health agency, is a generic document. Nothing in the structure of the MOUs suggested that they were structured to apply only to certain managed care enrollees, such as Medicaid-sponsored members. In fact, the Ohio document specifically referenced its applicability to all members of any plan offered by the MCO, not merely its Medicaid enrollees.

The universality of the documents is consistent with the basic nature of the managed care enterprise. It is conceivable that an MCO which negotiated an MOU with a local health agency might insist on limiting its scope only to its Medicaid business. But just as a public health agency views its mission and obligations in a community-wide fashion, an MCO views its members as a group, not by the particular sponsor that pays for their enrollment. Thus, both health agencies and MCOs could be expected to view their relationship as transcending any particular sponsor and relevant to all members.

This is not to say that a specific sponsor might not want special considerations built into the agreements that an MCO structures with its network (an example of such special considerations would be the unique benefit and cost sharing rules that apply to Medicaid managed care). Other than these special considerations, however, the very nature of managed care underscores the desirability of having network agreements that apply across all product lines. An MCO is a large, complex, vertically integrated corporate structure that, like any large company, depends for its efficiency and financial success on control, uniformity, and standardization. It is logical that were a managed care company to negotiate successfully an agreement with a local public health agency, it would want the agreement to apply throughout its products, not just in selected cases.

MOUs as reflective of managed care rather than public health imperatives: The MOU analysis shows that the documents are structured to function much like any traditional provider network service agreement. Thus, they tend to address only in very limited ways (and frequently not at all) those aspects of the public health/managed care relationship that pertain to the ability of public health agencies to carry out all aspects of their missions. The documents codify the managed care business relationship (e.g., the local public health agency's rights and duties as a member of the MCO's provider network). Many of the public health mission-related issues may in fact arise during the negotiations over the MOUs and could result conceivably in informal "side agreements." However, these side agreements are not a formal part of the MOU documents, nor did our interviewees suggest the existence of another set of agreements that supplement the written ones they either had, or hoped to, establish with MCOs. It is also important to note that in the case of executed MOUs, other agreements outside of the written document and its referenced attachments would not be enforceable. Thus, for example, if an MCO promised to do its best to ensure that its laboratory suppliers would furnish the results of STD-related diagnostic tests to the public health agency epidemiological surveillance branch, the absence of a written guarantee probably would make it unenforceable.

Similarities and differences among MOUs: Table 1 sets forth the elements of the MOUs. Nearly all reflected the public health agencies' view of the importance of furnishing plan members with certain personal health services that are covered by the MCO contract and essential to public health (e.g., family planning, immunizations, screening and treatment for STDs and HIV, treatment of tuberculosis). Moreover, since these services show up in both the pending and signed MOU agreements, they reflect a view on the part of MCOs that public health agencies do, indeed, have a role to play in the provision of personal health services, whether for Medicaid beneficiaries or other members. Overall, half of the MOUs examined address reimbursement for STD services provided by the local public health agencies.

The MOUs vary greatly in the range and scope of services they cover, a fact which is driven probably as much by the uniqueness of local health agencies as the purchasing expectations of the MCOs. Table 2 on page 22 expands on Table 1 by illustrating differences in the scope and specificity of STD-related language that is found in the MOUs in use at four sites. Two of the MOUs contain extensive language

relating to STD services, while the other two are less comprehensive in scope and specificity. For example, the Sacramento County model MOU contains extensive provisions related to how health plans and the public health agency should relate to each other in the areas of STD prevention and treatment. The language covers the use of liaisons by the plan and the agency, access to care, confidentiality, disease reporting, provider payment, coordination of care, and coverage of diagnostic and treatment services. By contrast, the Marion County, Oregon agreement contains shorter and less detailed STD provisions and addresses fewer issues than the Sacramento agreement. Of particular note is the absence of provisions in the MOUs relating to health agency access to the results of MCO laboratory tests or empirical diagnoses in the area of STDs. Many health agencies traditionally have relied on public health laboratories rather than individual clinicians for information on people diagnosed with STDs (since individual clinicians often treat with presumptive diagnoses and do not report cases to the health departments). As MCOs alter traditional laboratory service patterns and contract with private and/or out-of-state laboratories for services, a critical source of information may be lost. However, this issue was mostly unaddressed either in the documents or in practice.

The Creation, Promulgation, and Implementation of MOUs

The on-site interviews revealed much about how the MOUs were conceptualized, promoted, and implemented. In the case of the MOU templates developed by state Medicaid agencies, both state and local health officials attributed their limited reach to the fact that the master agreement between the Medicaid agency and its MCOs did not, or only to a limited degree, address public health policy and practice issues. Thus, in turn, their ability to address the full range of issues of concern in their own negotiations with the MCOs was constrained.

The accuracy of this assertion bears closer scrutiny. From CHSRP's work on master agreements, it appears that Medicaid agencies tend to develop their agreements on their own and with, at times, only limited consultation with other affected agencies, including public health.[10] At the same time, however, public health agencies have an independent basis of legal authority under state law. In theory at least, their police powers would authorize them to develop conditions of participation for MCOs that do business in the state. Furthermore, in a number of states, public health agencies actually control the body of regulatory law that establishes conditions of participation for HMOs and other health insurers. Thus, even if a health agency were to play only a limited role in shaping a Medicaid/MCO contract, it could exercise its independent powers to frame additional conditions of participation. This use of legal authority to shape managed care arrangements to conform to public health imperatives, such as access to data, the maintenance of confidentiality of certain information between providers and patients, or the conditions of coverage and payment for network providers that are local public health agencies, appeared to be lacking as a general matter.

State health agency officials reported that they believed that if they had been consulted earlier in the process, there would have been greater opportunity for inclusion of public

health concerns. In subsequent rounds of contracting, Medicaid agency staff reported greater consultations with health agencies. However, even the later agreements collected in the second wave still reflect an MOU model that parallels provider arrangements for specific services rather than for population-based public health activities.

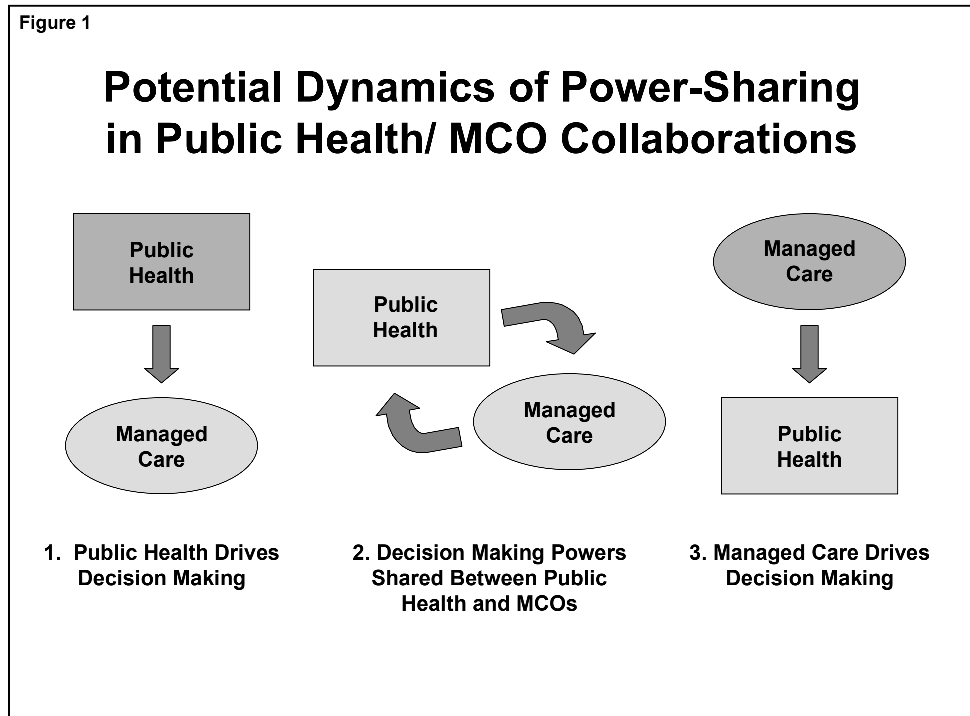
Discussions with health department officials also revealed that, as is often the case with major organizational transformations, the presence of an official who "adopts" the MOU process and shepherds it through the development and negotiation phases was a critical factor in promoting the coverage of a broader range of issues in the MOU agreement. This was particularly true in Onondaga County, New York, and in California, where local public health commissioners took leadership roles in convening affected stakeholders for MOU development and negotiation. A leader of this process in Harris County, Texas was a health department official who had significant private sector experience in public relations.

In Detroit, Michigan and Shelby County, Tennessee, the local health departments, dissatisfied with the MOU guidelines offered by their own state health agencies, wrote their own service provider agreements to address primary care services which were not included in the state model agreements. These local health departments perceived the need to expand the basic document because their service missions covered both the primary and specialty care services for people with complex medical needs. Officials in these local health departments believed they had a vested interest in continuing the provision of primary care services, both to preserve their access to Medicaid revenues, and to assure the provision of a comprehensive array of services to their communities. However even in these sites, the MOUs, which focus on a greater range of services, do not address MCO obligations towards facilitating any public health agency population-based functions.

Managed care officials interviewed during the study also reflected the differences among managed care companies in their outlooks regarding their interaction with public health agencies. Medicaid-only MCOs, which have had significant experience as providers in the fee-for-service system, reported that they have special expertise in understanding the provision of both health and enabling services (such as cultural competency, transportation, translation, etc.) for Medicaid enrollees. Other MCOs that were new Medicaid market participants, such as large operations that also serve commercial enrollees, reported that they were still learning about the special needs and characteristics of Medicaid enrollees. In some cases like New York, MCOs employed professional staff with public health backgrounds, such as nurses, who brought their expertise to the organizations and facilitated the learning process.

Allocation of Treatment Decision-Making and Data Authority

As noted, a critical factor in the public health/managed care relationship is the allocation of treatment decision-making and data analysis powers in the area of STDs and other communicable diseases between local health departments and MCOs. Figure 1 shows that there are three potential approaches to the allocation of data analysis and treatment decision-making powers between public health and managed care.



In scenario 1, public health officials reserve to their agencies the power to make these decisions and set the terms of participation for the MCOs. Under this scenario, a managed care network would agree to adhere to public health practice guidelines in the area of STDs, and the utilization management staff would adhere to such guidelines as well as individual treatment orders when managing members with STDs, including members receiving compulsory treatment. Data from MCO suppliers relevant to the surveillance of STDs (particularly information from laboratories and pharmacies) would be supplied to public health agencies for use in both epidemiological work and other public health activities such as partner notification.

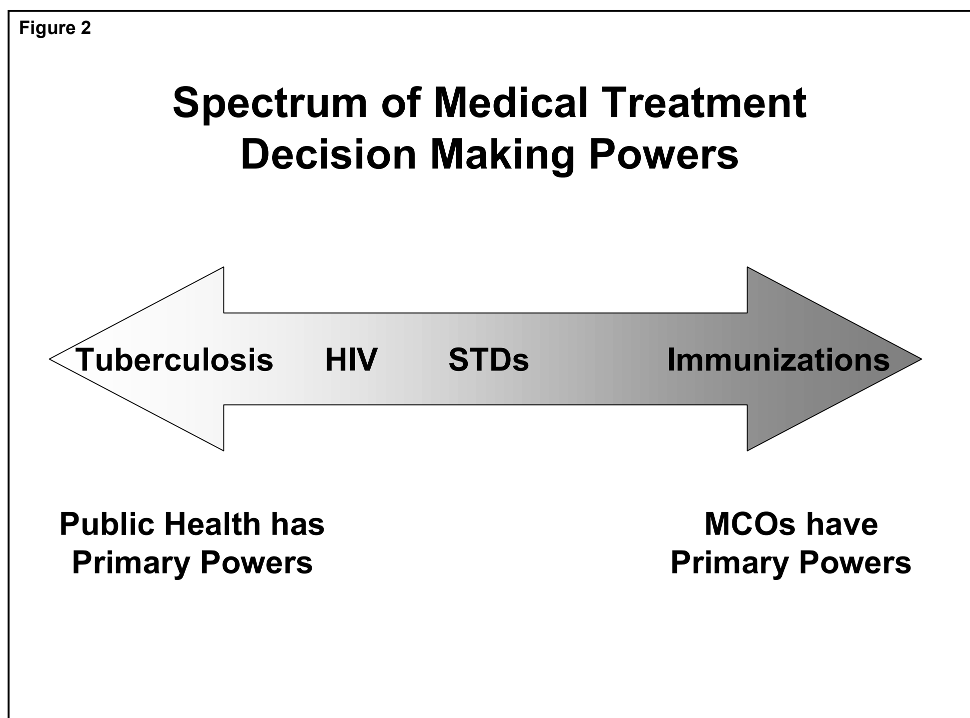
In scenario 3, the reverse is true: the MCO defines its practice standards and makes all decisions regarding the timing, content, duration and appropriateness of treatment. The MCO also retains control over data not otherwise subject to a mandatory public health reporting statute. In scenario 2, powers for treatment decision making are negotiated between the two entities with the goal of achieving a balance.

Scenario 3 was the most common finding in this study. That is, the MOUs did not address these matters and the MCOs thus reserved the right to set practice guidelines and render treatment decisions. The analysis of the MOUs revealed two notable exceptions. In the case of the model agreement developed by the Onondaga County Health Department, the agency retained the power to make all treatment decisions for people with tuberculosis. In addition, the MOUs generally specified that in the case of Medicaid enrollees, the Medicaid freedom of choice requirement for family planning[11] would permit Medicaid-sponsored members to receive care from any Medicaid-qualified provider.

An earlier study for the Kaiser Family Foundation conducted by CHSRP[12] found that Medicaid agencies classify STD testing as a family planning service; as a result, at least in the area of STD testing, Medicaid-sponsored plan members would be able to obtain care from any qualified provider, regardless of its network status. Thus, even if an MOU containing this provision did not establish the health agency as a full network provider, the health agency could nonetheless perform STD testing services for Medicaid members and obtain payment. However, the MOUs were silent on how a member who tested positive for an STD at a health department site would be referred back to the plan for treatment. This silence regarding procedures for referral for treatment to the MCO of members who test positive for an STD is consistent with the findings from the earlier study regarding the lack of coordination between non-network testing sites and MCO-covered treatment services.

As noted, unlike STDs, tuberculosis tended to receive special treatment along this "spectrum" of possible public health/managed care relationships. Figure 2, which shows the range of allocation of powers for specific types of communicable diseases, illustrates the special status of tuberculosis.

Figure 2



Public health authorities in about half of the study sites required that MCO enrollees suspected of having, or diagnosed with, tuberculosis be referred to the health department for treatment, reflecting both public health's historic imperative to control the spread of tuberculosis and the reemergence during the 1980s of tuberculosis as a widely recognized public health threat. The clearest example of public health asserting its powers for TB control was in the Onondaga County Health Department, which reserved the right to make all treatment decisions, including hospitalization and directly-observed therapy, and stipulated in its MOU an annual case rate fee of $2,250 per patient (excluding hospital costs) to be paid by the MCOs.

In the case of STDs, however, there was essentially no evidence of movement to allocate decision-making powers over treatment to the public health agency. Again, since these MOUs were drafted not by MCOs but rather by public health and Medicaid agencies, this failure to classify STD treatment as a public health imperative by insisting on the maintenance of control over treatment decision-making suggests that STDs are viewed as a more mundane public health matter and as a set of conditions over which public health agencies need to maintain much less control. Public health and MCO interviewees in several sites acknowledged that STDs are not even "blips on the radar screen" in discussions concerning priorities for developing the public health/managed care relationship.

Because the MOUs do not appear to empower health agencies to influence the standards for testing and treatment of STDs within MCO practices, important issues are left to the discretion of MCOs. For example, rapid testing of specimens may be essential to the control of STDs.[13] Yet nothing in the MOUs allowed the health agency to utilize a rapid testing site in the event that the MCO's laboratory was unable to meet the timelines specified in public health guidelines for testing and treatment of STDs. Similarly, nothing in the agreements allowed a health agency to order the coverage of a drug that may be optimally effective in the treatment of a particular STD but that does not appear on the MCO's formulary. An MCO may in fact decide to supplement its laboratory or pharmacy services as a public health measure. But the MOUs left these matters to the sole discretion of the MCO.

Compensation for Services

The issue of compensation brought into sharp relief the challenges underlying the public health/managed care relationship. Most insurers do not pay for services furnished by public health agencies, instead excluding them as "free" care or "public" services. Medicaid of course is different; for years Medicaid has represented an important source of revenues for public health agencies that furnish covered services to beneficiaries. Thus, while the MOUs might create new revenue streams when applied to privately insured members, they function as a means for preserving existing revenues in the case of Medicaid-sponsored members.

Reimbursement and billing issues brought to the fore certain unresolved tensions between the insurance functions of MCOs and the public health functions of public health agencies. To encourage people to be tested and treated for communicable

diseases, public health agencies often provide confidential and/or anonymous services. CHSRP's earlier study for the Kaiser Family Foundation found that local public health agency concerns about patient confidentiality impeded their willingness to bill MCOs for STD services. The interviews conducted for this study confirmed the continued existence of this concern.

Despite the fact that confidentiality concerns were the most frequently cited reason by public health officials for not billing MCOs for services, and despite the fact that public health agencies played a role in designing most of the MOUs examined in this study, the documents did not contain provisions prohibiting MCOs from conditioning payment on the provision of confidential patient data.[14]

Other reasons cited for not billing MCOs included the high administrative costs of maintaining a billing system that is compatible with the requirements of multiple MCOs, and the declining number of Medicaid-eligible clients as a source of revenue (the majority of the public health STD and HIV clinic clients were uninsured or chose to self-pay). Interestingly, many agencies reported that they had access to other, unrestricted revenues to cover the cost of their services. Since most of the revenues for the treatment and management of STDs come from federal grants from the CDC and other federal programs, this assertion tended to underscore that federal grant funding is effectively cross-subsidizing the cost of caring for MCO enrollees, as publicly funded health providers reject MCO revenues in favor of more loosely restrictive funding arrangements.

Data and Case Reporting

With the exception of New York and California (see Table 2), the agreements did not obligate the MCOs to provide public health agencies the necessary information to carry out either their epidemiological surveillance activities or to conduct other activities that are essential to the control of STDs. The most notable activity potentially affected by the absence of such data is the notification of people who have come into contact with someone who has an STD and the arranging of testing and treatment for possibly infected partners. Since many partners may not be members of the MCO to which the infected person belongs, the ability to carry out notification activities and support the cost of treatment is pivotal.

When queried about why the MOUs did not cover access to data for either surveillance or partner notification purposes, most MCO officials expressed the belief that existing public health laws governing the mandatory notification of reportable diseases already covered this matter and that their obligation to make data available was an unnecessary burden. In fact however, a related follow-up review of state notifiable disease statutes conducted by CHSRP indicates that while most state laws cover both physicians and laboratories (laboratories, not physicians, are the prime source of information about notifiable diseases), only one state (New York) classifies any laboratory that tests specimens drawn in the state as doing business in that state and requires a laboratory to report the test results, regardless of its location. Since many MCOs use centralized laboratory services that are furnished by out-of-state suppliers, state public health laws in fact may not reach this critical source of data.[15]

Dissemination of Standards of Care

The MOUs frequently referenced certain established public health standards for testing and treating communicable diseases, such as those established by the CDC and the Advisory Committee for Immunization Practices. Most MCOs reported that they disseminated to their contracted providers the public health standards of care for HIV counseling and testing, especially for pregnant women and for childhood immunizations. None of the MCOs disseminated standards of care specific to STDs. Most MCOs disseminated standards of care on other issues considered “hot topics,” such as teenage pregnancy or smoking cessation. One Oregon MCO official stated that the plans see themselves more as payers than as managers of care and assume that providers “know what they are doing.” MCO officials attributed this “hands-off” attitude to their perceptions that physicians desire clinical autonomy of judgment as well as the MCOs’ desire to avoid even the appearance of practicing corporate medicine. It is also important to stress that while the MOUs address the dissemination of practice standards, they do not contain provisions that would obligate the MCO, in making treatment decisions, to adhere to the standards that have been disseminated.

Discussion

Historically, public health has had a complex relationship with the American medical care system. Medical care providers, whether physicians and other health professionals practicing in traditional fee-for-service settings or large medical corporations furnishing vertically integrated health care products to group sponsors, traditionally have insisted on nearly unfettered autonomy in both the practice of medicine and their relationship to the broader issues of public health. The movement to managed care has, if anything increased the desire for autonomy, since MCOs operate competitively, at financial risk, and on pre-established budgets that in their view further increase the need for independent decision-making over the allocation of health care resources.

Managed care offers public health officials important new opportunities for integrating public health policy and practice with medical care. Both MCOs and public health agencies are fundamentally oriented to the overall health of broad populations rather than the particular needs of individuals. Both public health and (at least in theory) managed care are interested in interventions that promote health and reduce illness and disability and share a common interest in population-wide interventions that advance overall well-being.

At the same time, managed care underscores the imperative for the modernization of public health policy and practice in critical areas, including confidentiality of services, access to data, and authority over treatment decision-making in areas of broad public health concern. The MOUs examined in this study are evidence of the limited understanding on the part of public health agencies of the ways in which managed care can render the fabric of public health policy outdated and incomplete. There exists no

better evidence of the need for the modernization of public health than a study that examines public health policies from the vantage point of STDs.

Conclusions

The findings from this study support several major conclusions. First, the fact that the MOU templates are not confined to specific group sponsors supports the conclusion that both public health and managed care view their relationship as systemic, rather than confined to certain portions of the managed care population. Even when developed in collaboration with certain purchasers (in this case, Medicaid agencies) the MOU templates examined in this study can be transferred to any population enrolled in an MCO. To be sure, there are certain aspects of Medicaid managed care that raise unique issues, such as a different benefit package and cost sharing rules or specific legal standards like free choice of family planning providers for enrollees. Nonetheless, the issues addressed in the MOUs apply to the entire population, not just Medicaid enrollees.

Second, the MOUs, which were developed either by health agencies or by Medicaid agencies in some level of collaboration with health agencies, demonstrate the limited understanding on the part of public health officials regarding the potential effects of managed care on the full spectrum of public health policy and practice. Critical issues, such as the authority of public health agencies to influence treatment decisions and practice standards for STDs, remain essentially unaddressed. Nor do the MOUs address issues such as access to data for surveillance and partner notification purposes or the concurrent need for the application of confidentiality protections to the MCO/public health agency relationship.

Third, to a remarkable degree, public health agencies view their role as secondary to that of purchasers rather than as primary to the protection of public health. When asked why the MOUs do not address overarching issues of public health practice, agency officials responded that they are limited in their ability to respond because they were not involved in the initial development of the master agreement between the group sponsor (in this case, Medicaid) and its contracting MCOs. The fact that public health agencies have an independent basis of authority over managed care practices that affect the public's health appears to have been largely overlooked, with the possible exceptions of the MOUs developed by California and New York officials. This tendency on the part of public health officials to disregard their own primary powers is not new; public health agencies have a history of avoiding interventions in medical care practice and autonomy, even when matters of public health are paramount. In the fee-for-service world, the licensure authority of public health agencies over physicians, hospitals, and other health care providers was the basis for regulating medical care in the broader interest of public health. In the world of managed care, health agencies continue to maintain regulatory powers and in many states, licensure authority. Yet this authority is seldom exercised, even in informally negotiated arrangements such as those embodied in MOUs.

Fourth, the relatively limited attention paid to STDs in the MOUs suggests that public health agencies place less emphasis on the control and treatment of STDs than other types of communicable disease. It is not unusual for MOUs to address matters of practice guidelines and treatment decisions in such areas as tuberculosis and immunizations. However, no MOUs required the adherence to public health standards with respect to STDs, and none addressed the issue of payment for treatment that met public health standards of practice. Given the current level of concern over the implications of uncontrolled STDs in communities, this lesser level of concern is somewhat difficult to understand. It is a matter worth further consideration by state and federal public health officials.

Fifth, the interviews with public health officials suggested that the presence of alternative sources of funding to support STD treatment and control may have diminished their interest in addressing the confidentiality and administrative barriers to managed care compensation for covered services. Understandably, public health agencies prefer to depend on alternative sources of funding to cover the cost of confidential testing and treatment rather than risk the loss of patients over the issue of disclosure. This study underscores the importance of sustained funding for such activities. Were federal and state policy makers to simply assume the availability of managed care funding for these services and to cease providing some or most grant funding, this study suggests that services simply would disappear rather than be moved to a new funding base, since the barriers to the use of managed care revenues remain essentially unresolved. At the same time, these alternative resources not only result in the use of public funds to subsidize contractual services but also may help avoid resolution of the central problem—the potential need to alter managed care practice and policy to accommodate confidential testing and treatment needs. Because the issue gets sidestepped, it is never properly debated.

Opportunities and Challenges

The widespread adoption of managed care creates major opportunities for public health interventions; at the same time, it raises new challenges. For the issues raised by this study to be properly addressed, public health agencies need to reconsider their basic orientation to managed care. Managed care affects more than the direct health care service obligations that devolve from the master agreement. Numerous aspects of managed care raise specific issues for public health agencies. In particular, these are the need to reexamine and update notifiable disease and privacy and confidentiality laws, and the need to consider new policies in the area of authority over treatment decision-making in cases involving communicable disease.

As public and private managed care purchasers become aware of managed care's potential impact on public health, they may be willing to make certain public health-related practices a basic contractual duty on the part of the companies with whom they do business. At the same time, the ultimate responsibility lies with public health agencies themselves to ensure that both public and private purchasers understand managed care's potential public health effects and to develop a comprehensive approach for the modernization of public health policy.

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

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

ELEMENTS OF MOUs	Onondaga County, NY[1] **	Sacramento County, CA[2]	Riverside County, CA[3]	Detroit, MI[4]	New Castle, Kent, and Sussex Counties, DE[5] **	Mont-gomery County, OH[6] **	Marion County, OR[7] **	Shelby County TN[8] **	Harris County, TX[9] **
1. GENERAL									
Medicaid agency/MCO contract or RFP addresses public health agency agreement	X	X	X	X	X	X	X	X	X
▪ Contract /RFP requires agreement		X	X				X		
▪ Contract /RFP provides authorization and/or incentives for agreement	X[10]			X	X	X[11]			X[12]
Non-contract incentive for agreement								X[13]	
Contracting public health agency is: ▪ Local agency	X	X	X	X		X	X	X	X[14]
▪ State agency					X				
Basic agreement drafted by: ▪ Public health agency	X	X	X	X	X		X[15]		X
▪ MCO						X		X	
2. BENEFITS AND SERVICE DUTIES									
Services for specified populations/ diagnoses/ conditions	X	X	X	X	X	X	X	X	X
▪ Children with special health care needs	X	X	X		X	X			
▪ Early intervention programs/ programs for children with developmental disabilities	X				X				
▪ Family planning services	X	X	X	X	X	X	X	X	X
▪ Hepatitis B screening of pregnant women	X							X	X
▪ HIV/AIDS	X	X	X		X		X	X	X
▪ Lead poisoning control	X	X						X	X

ELEMENTS OF MOUs	Onondaga County, NY **	Sacramento County, CA	Riverside County, CA	Detroit, MI	New Castle, Kent, and Sussex Counties, DE **	Mont-gomery County, OH **	Marion County, OR **	Shelby County TN **	Harris County, TX **
2. BENEFITS AND SERVICE DUTIES CONTINUED									
▪ Neural tube defects/ spina bifida	X								
▪ Other communicable diseases	X	X	X	X	X		X	X	
▪ Pediatric and adolescent health services; EPSDT	X	X	X	X	X		X	X	X
▪ Perinatal services	X		X	X	X		X	X	X
▪ Pharmacy services				X	X	X		X	X
▪ Refugee health care		X							
▪ School health services	X			X				X	
▪ Sexually transmitted disease	X	X	X	X	X	X	X	X	X
▪ Substance abuse				X					X
▪ Tuberculosis	X	X	X	X	X	X		X	X
▪ Vaccine-preventable diseases (immunization services)	X	X	X	X	X	X	X	X	X
▪ WIC	X	X	X						X
Medical necessity determinations or prior authorization for public health services	X				X	X	X	X	X
▪ By MCO					X	X	X	X	X
▪ By public health agency	X								
3. NETWORK STANDARDS									
Network status of public health agency	X	X	X	X	X	X	X	X	X
Use of certified laboratories & reporting of data to public health laboratories		X	X				X	X	

ELEMENTS OF MOUs	Onondaga County, NY **	Sacramento County, CA	Riverside County, CA	Detroit, MI	New Castle, Kent, and Sussex Counties, DE **	Mont-gomery County, OH **	Marion County, OR **	Shelby County TN **	Harris County, TX **
4. ACCESS MEASURES									
Confidentiality of care			X		X	X	X	X	X
Member outreach, education	X		X		X	X			X
▪ By MCO	X		X						
▪ By public health agency	X		X		X	X			X
Parental consent for services									X
Referral:	X	X	X	X	X	X	X	X	X
▪ MCO member self-referral to public health agencies	X	X	X	X	X	X		X	X
▪ MCO provider referral to public health agency	X	X	X	X	X	X			X
▪ Public health agency to MCO	X	X	X	X	X		X	X	X
5.QUALITY ASSURANCE AND PERFORMANCE MEASUREMENT									
Education of network providers on public health issues and services	X		X						X[16]
▪ By MCO	X		X						
▪ By public health agency	X		X						X[16]
Participation in infant mortality/morbidity reviews	X								
Quality performance standard setting & performance measurement	X		X	X		X	X	X	X
▪ MCO use of public health service standards for one or more diseases	X		X					X	
▪ Public health agency monitoring of MCO provider performance			X						

ELEMENTS OF MOUs	Onondaga County, NY **	Sacramento County, CA	Riverside County, CA	Detroit, MI	New Castle, Kent, and Sussex Counties, DE **	Mont-gomery County, OH **	Marion County, OR **	Shelby County TN **	Harris County, TX **
6. RECORD STANDARDS AND REPORTING DUTIES									
Access to books/records	X	X	X		X	X	X	X	X
▪ Of public health agency			X		X	X	X	X	X
▪ Of MCO	X	X					X		X
Access to sharing of data		X	X						
▪ By MCO		X	X						
▪ By public health agency			X						
Data reporting by health agency	X	X	X		X	X		X	X
▪ Care furnished and /or follow-up of member health care needs	X	X	X		X	X		X	X
Data reporting by MCO	X	X	X		X		X		
▪ Notifiable diseases	X	X	X						
▪ Care furnished and /or follow-up member health care needs	X				X		X		
▪ VFC data		X	X						
Provision of immunization records to members		X	X						
▪ By MCO		X	X						
▪ By public health agency			X						
7. POPULATION-BASED ACTIVITIES									
Cancer epidemiology	X								
Development of service area immunization plan				X					
▪ By MCO				X					
▪ By public health agency									X*
MCO relationship to VFC: Program Participation by MCO providers		X							

ELEMENTS OF MOUs	Onondaga County, NY **	Sacramento County, CA	Riverside County, CA	Detroit, MI	New Castle, Kent, and Sussex Counties, DE **	Mont-gomery County, OH **	Marion County, OR **	Shelby County TN **	Harris County, TX **
7. POPULATION-BASED ACTIVITIES CONTINUED									
Participation in immunization registries/tracking systems		X	X	X					X
▪ By MCO		X	X	X					
▪ By public health agency		X	X						
Partner/contact notification and disease surveillance	X	X	X		X				X
▪ By MCO		X							
▪ By public health agency	X	X	X		X				X*
Service area needs assessment	X								X*
▪ By MCO	X								X
▪ By public health agency	X								
8. BUSINESS RELATIONSHIP									
Indemnification	X	X	X			X	X	X	
▪ MCO duty to indemnify	X	X	X			X	X	X	
▪ Public health agency duty to indemnify	X	X	X			X	X	X	
Liaisons and Meetings		X	X						
▪ MCO duties		X	X						
▪ Public health agency duties		X	X						
Medicaid eligibility determination/MCO enrollment		X				X	X	X	X
MCO payment to public health agency	X	X	X	X	X	X	X	X	X

Table 1 Notes

[1] Public Health-Managed Care Partnership Agreement between Onondaga County and Managed Care Plan.

[2] Draft Medi-Cal Managed Care Agreement.

[3] Agreement between Molina Medical Centers and Riverside County Health Services Agency.

[4] Detroit Health Department, Model Fee for Services Agreement with Qualified Health Plans.

[5] Master Agreement between Delaware Division of Public Health and MCD Health Services Corporation: First State Health Plan.

[6] Participating Provider Agreement with Reimbursement Schedule (Attachment C) setting forth reimbursement rates for specified services furnished to both Medicaid and commercial enrollees by the Communicable Disease Clinics of the Combined Health District, Montgomery County.

[7] HMO [omitted word(s)] Medical Services Agreement.

[8] Blue Cross and Blue Shield of Tennessee Group Practice Agreement (includes Attachment BLUECARE Group Practice Primary Care).

[9] Agreement between “Alpha Texas, Inc.” and Harris County (“Alpha Texas, Inc.” is a pseudonym used for demonstration purposes in the model agreement.)

[10] The New York RFP states that “preference” will be shown in awarding of Medicaid managed care contracts to MCOs that “offer contracts to such traditional providers” as public health departments; New York site visit informants indicated that such contracts were required, but the source of the requirement is unclear.

[11] Ohio site visit informants identified an enrollment performance standard in the Ohio Medicaid managed care contract as a key factor in establishing agency-MCO agreements. The standard requires that MCOs enroll at least 15% of a county’s Medicaid eligibles (10% in smaller counties) by June 30, 1998 or lose eligibility to continue serving Medicaid enrollees.

[12] Texas site visit informants identified a preference in the procurement for process for MCOs that included local health agencies in their provider networks as a key factor in establishing agency-MCO agreements.

[13] Tennessee site visit informants identified legislative diversion of $15 million annual state funding for public health functions as a key factor in the state health department decision to seek agency-MCO agreements.

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

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

[16] The documents address health agency education of “medical providers and hospitals in the community” without specifically addressing education of MCO network providers.

Table 2: SERVICES RELATING TO SEXUALLY TRANSMITTED DISEASES IN AGREEMENTS BETWEEN MEDICAID-SERVING MANAGED CARE ORGANIZATIONS AND PUBLIC HEALTH AGENCIES—SELECTED SITES
[*Note: Emphases added*]

Onondaga County, New York	"…County will provide STD services at patient's request without seeking prior authorization from the Plan. County will continue to provide direct clinical services through its County STD clinics. The County shall make all reasonable efforts, consistent with current law and regulations and with patient consent, to report confidential reports to the Plan and inform the patient of the availability of STD services in-plan…[and provide services as set forth in attachment, which addresses a) appointment of plan and health department liaisons; b) *health department provision of STD services, without charge to patient or to plan*; c) plan duties to '[e]ncourage all members to seek STD services at their plan or from County STD clinics [and to not require prior authorization or restrict the number of visits needed for outpatient or inpatient diagnosis, treatment and counseling]; d) *plan duties to provide to health department completed STD disease-reporting forms, ensure laboratory reporting and 'educate' plan providers regarding 'the need to provide OCHD with information on STD patients and/or partners of STD patients'*; e) plan duty to 'develop and implement STD screening and treatment protocols based on State and County recommendations and *report 'non-compliant' patients to health department'*; f) health department duty to furnish: 'protocols and procedures for the evaluation of partners of STD-infected members [and] [p]rovide follow-up of contacts for all STD patients'; and g) provision of medical and public health consultation by health department, and plan duties to inform providers of availability of such consultation.]…"
Sacramento County, California	[Plan responsibilities (set forth in matrix) include]: "implement[ing] procedures to ensure that Members have prompt access to appropriate STD prevention, screening, counseling, diagnosis and treatment services…[and to] allow members to access STD services by selecting a provider other than the member's PCP if he/she desires confidentiality…[and to] allow minors aged 12 and older to access STD services without parental consent…[and to protect member confidentiality]. [also to] *provide COUNTY with completed California Morbidity Reports (CMRTs) on patients with reportable diseases…Implement procedures to monitor compliance of PLAN providers of STD services with communicable disease reporting requirements. Ensure the PLAN's clinical laboratories provide COUNTY with required information on patients with reportable STDs*…Reimburse…COUNTY for the diagnosis and treatment of [specified] STDs…*Inform PLAN providers regarding the importance of rapidly notifying sex partners* of infected PLAN Members so they can be tested and receive appropriate counseling and treatment at the earliest opportunity. Forward medical documentation to the PCP"….[and matrix with definitions of reimbursable services per episode of specified STDs]
Marion County, Oregon	"…COUNTY [LHD] and its employed health care professionals may provide the following Medically Necessary Services within the scope of licensure or certification of COUNTY's employed health care professionals:… 2. Diagnosis and treatment of sexually transmitted diseases… All services will be provided according to the Office of Medical Assistance Program's practitioner's Handbook for Medical-Surgical Services, January 1995, and associated amendments…"
Shelby County, Tennessee	"…Covered services…include:… 3. HIV, STD and TB testing and treatment…"

END NOTES

[1] *See, for example*, Eddy D. “Rationing resources while improving quality: how to get more for less.” *JAMA* 1994;272:817-214; and Harris JR, Caldwell B, Cahill K. “Measuring the public’s health in an era of accountability: lessons from HEDIS.” *Am J Prev Med* 1998;14(3S):9-14.

[2] Institute of Medicine. *The Future of Public Health*. National Academy Press, Washington D.C., 1999.

[3] For an analysis of the national prevalence and incidence of STDs and the emergence of anti-microbial strains of disease, see Eng TR, Butler WT, eds. *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*. Washington: National Academy Press; 1997. Sponsored by the Institute of Medicine. Available at http://www.nap.edu. An analysis of the public health and medical cost burdens of STDs can be found in *Sexually Transmitted Diseases in America: How Many Cases and at What Cost?* Prepared for the Kaiser Family Foundation by the American Social Health Association, December 1998. Available at http://www.kff.org.

[4] See sample managed care purchasing specifications relating to STDs, developed by the George Washington University Medical Center, School of Public Health and Health Services (CHSRP) for the CDC. Available at http://www.gwu.edu/~chsrp.

[5] The Center for Health Services Research and Policy (CHSRP, formerly the Center for Health Policy Research) conducts sponsored health services research and policy analysis on complex health policy issues. CHSRP is the major health services research center for The George Washington University Medical Center, and is located within the School of Public Health and Health Services. CHSRP identifies, monitors, and analyzes emerging issues in federal and state health law and policy and evaluates the effects of changing federal policies on health care access, quality, and cost at the state and local levels. CHSRP research projects are conducted and overseen by an interdisciplinary faculty and staff who combine formal academic training with a variety of professional backgrounds in law, government, economics, politics, management, nursing, and medicine. Projects are carried out both alone and in collaboration with various entities, such as other University research centers, departments within the University’s Medical and Public Health Schools, and other policy and research analysis organizations throughout the country.

[6] Onondaga County, New York; Hennepin County, Minnesota; Detroit, Michigan; Sacramento and Riverside Counties, California; Shelby County, Tennessee; Harris County, Texas; Marion County, Oregon; Montgomery County, Ohio; and Kent, New Castle, and Sussex Counties, Delaware.

[7] In 1996, the Minnesota legislature enacted legislation entitled “Collaboration Plan” (Minn. Laws, 1996, Ch. 451, Art. 1 §3) that requires MCOs to engage in service area planning that takes into account one or more of 17 public health goals and to make planning documents available for public input. The legislation contains no requirements for the development of written agreements such as MOUs, nor did the state health or Medicaid agencies develop a standard provider agreement at the time of the site visits.

[8] Certain medical and health services tend to be unique to Medicaid and generally are not found in commercial insurance. However, many of the types of treatments required for the identification and management of STDs (the services of health and medical professionals, laboratory tests, and prescribed drugs) are typically covered by both publicly and privately purchased managed care products.

[9] CHSRP has done extensive analysis of managed care network provider agreements. See, Rosenbaum S, Silver K, and Wehr E. *Principal Findings from an Analysis of Contracts Between*

Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Programs. (DHHS/SAMHSA, June 1997); Rosenbaum S, and Serrano R. *Principal Findings from An Analysis of Agreements between Primary Care Group Practices and Managed Care Organizations (*The George Washington University Medical Center, CHPR, Washington D.C., 1996); Rosenbaum S, Mauery DR, Teitelbaum J. *Principal Findings from An Analysis of Agreements between Managed Care Organizations and Community-Based Mental Illness and Addiction Disorder Treatment and Prevention Programs* (2d ed.) [forthcoming from DHHS/SAMHSA, 2000]. For a general discussion of contracts between managed care organizations and health care providers see Rosenblatt R, Law S, Rosenbaum S. *Law and the American Health Care System* (Foundation Press, NY, NY 1997; 1999-2000 Supplement (Ch. 2(J)).

[10] Rosenbaum S, Sonosky CA, Shaw K, et al. *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (3rd Edition). Center for Health Services Research and Policy, The School of Public Health and Health Services, The George Washington University Medical Center. Washington, D.C. June 1999.

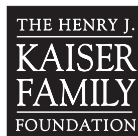
[11] §1902(a)(23) of the Social Security Act; 42 U.S.C. §1396a(a)(23).

[12] Rosenbaum S, Shin P, Mauskopf A, Funk K, Stern G, Zuvekas A. *Beyond the Freedom to Choose: Medicaid Managed Care and Family Planning*, (full report), 1994. The Center for Health Services Research and Policy, The School of Public Health and Health Services, The George Washington University Medical Center, Washington, DC.

[13] Sample purchasing specifications. See endnote 4.

[14] Legal principles of confidentiality preclude the disclosure of information to a third party without the express consent of a patient. However, an MCO is arguably not a “third party,” since it is the entity that actually undertakes to provide care to a member through its network of agents or employees. Even if the MCO is in fact a third party, no state appears to expressly prohibit MCOs from conditioning payment on the release of confidential data, even though such a condition could arguably be against public policy.

[15] Attendees at the Fall 1998 national meeting of the American Society of Microbiology noted that in at least one state, the use of out-of-state laboratories by MCOs was so widespread that the state health agency had seriously underreported the presence of STDs in the state because it was lacking so much data. Dalton, R. “Lab Chiefs Warn of HMO Cost Pinch.” *The San Diego Tribune*. Page B-3:1,7,8; B-4:3,5. September 29, 1998. For an analysis of the effects of changes in health services delivery and financing on clinical laboratory functions in public health, see, e.g., Rose NR. “Clinical Microbiology in the Changing World of Health Care Management.” Prepared for the American Academy of Microbiology. 1998; and “The Impact of Managed Care and Health System Change on Clinical Microbiology: A Survey Analysis.” Prepared by The Lewin Group for the American Society for Microbiology. September 1998.



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