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# Prevention and Managed Care: Opportunities for Managed Care Organizations, Purchasers of Health Care, and Public Health Agencies

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# Prevention and Managed Care: Opportunities for Managed Care Organizations, Purchasers of Health Care, and Public Health Agencies

***Summary***

*The rapid, extensive changes in the health-care system in the United States provide public health agencies with new opportunities for prevention-oriented relationships with the private health-care system. Managed care organizations (MCOs) are rapidly becoming a major source of health care for the beneficiaries of both employer-funded care and of the publicly funded programs, Medicaid and Medicare. In addition, MCOs represent organized care systems that often focus their efforts on defined populations and are accountable for desired outcomes, including prevention activities. In recognition of the potential role of managed care in prevention, in January 1995, CDC formed a Managed Care Working Group to develop recommendations for CDC for fostering the incorporation of prevention practices into managed care. This report presents these recommendations and approaches for their implementation, as well as background and case examples.*

## INTRODUCTION

In January 1995, CDC formed an agency-wide Managed Care Working Group to guide its efforts to foster partnerships between public health agencies at the national, state, and local levels and the rapidly growing managed care industry to promote prevention and improve the public's health. In March 1995, the Working Group initiated development of a prioritized list of activities for CDC, which then invited representatives of key groups—including the Association of State and Territorial Health Officials, the Group Health Association of America (GHAA), the Health Care Financing Administration (HCFA), the National Association of County and City Health Officials, and the CDC Director's Advisory Committee—to a series of consultations to review the proposed activities.

This report presents a) a brief summary of the systems for financing and delivery of health care in the United States, b) a review of the relationship between managed care and prevention, c) examples of the incorporation of prevention practices into managed care, and d) a list of the recommendations developed by the Managed Care Working Group for CDC's role in fostering the incorporation of prevention into managed care.

## THE FINANCING AND DELIVERY OF HEALTH CARE

The financing and delivery of health care in the United States are rapidly evolving, and the term *managed care* covers a variety of arrangements that continue to be adapted and developed. Four entities are involved in the financing and delivery of health care: the individual consumer, the provider of care, the insurer who reimburses for care, and the purchaser of the care. This section provides descriptions of

alternative arrangements for the financing and delivery of health care and focuses on the relationships among the four entities. The term **managed care** can include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and utilization review. In this report, HMOs are referred to as the most fully developed managed care organizations and those most amenable to prevention initiatives.

The two broadest divisions of arrangements for financing and delivery are fee-for-service indemnity and prepaid health care. Under **fee-for-service indemnity** arrangements, the consumer incurs expenses for health care from providers whom he/she generally selects. The provider is reimbursed for covered services in part by the insurer and in part by the consumer, who is responsible for the balance unpaid by the insurer. Under indemnity arrangements, the provider and the insurer have no relationship beyond adjudication of the claim presented for payment, nor is there a mechanism for integrating the care the consumer may receive from multiple providers.

A variant of the fee-for-service indemnity arrangement is the **preferred provider organization**, which contracts with providers in the community to provide covered services for a discounted fee. Providers under contract are referred to as "preferred providers." Usually the insurer and the consumer pay less for services received from preferred providers than for those received from other providers. Generally, PPOs do not determine guidelines for preferred providers to follow.

Under **prepaid health care** arrangements, the insurer and provider functions are integrated under the HMO umbrella. Generally, the consumer agrees to use the HMO's providers for all covered health-care services. The HMO provides comprehensive and preventive health-care benefits for a defined population. It agrees to provide all covered health-care services for a set price, the per-person premium fee. The consumer may pay additional fees (co-payments) for office visits and other services used. The HMO also organizes the delivery of this care through the infrastructure it builds among its providers and the implementation of systems to monitor and influence the cost and quality of care. The risk for the cost of care for the enrolled population is assumed by the HMO.

Another common characteristic of HMOs is **capitation**, which is a negotiated amount that an HMO pays monthly to a provider whom the enrollee has selected as a primary care physician. The provider is responsible for delivering or arranging for the delivery of health-care services required by the enrollee. This capitation is paid regardless of whether the physician has provided services to the enrollee. In a capitation arrangement, the physician shares with the HMO a portion of the financial risk for the cost of care provided to enrollees.

HMOs establish their provider networks by following one or more model types, which are defined by the nature of the arrangement between the HMO and the provider:

- In a **staff-model HMO**, the providers are employed by the HMO and practice in common facilities. The providers, as employees, are expected to follow the practices and procedures determined by the employer, in this case, the HMO.
- In a **group-model HMO**, the HMO contracts with a multispecialty provider group that agrees to provide on an exclusive basis all covered services for the enrolled population of the HMO. The group negotiates a financial arrangement with the

HMO on behalf of the providers who practice in the group. The providers who are members of the group may be either owners or employees of the group, which establishes the practices and procedures the providers follow.

- In a **network-model HMO**, the HMO contracts with two or more multispecialty provider groups that agree to provide all covered services for the enrolled population of the HMO. The groups may contract with other HMOs and may care for consumers on a fee-for-service basis. The individual provider contracts with the group practice of his or her choice. The HMO determines practices and procedures to guide the services rendered to its enrolled population.
- Under an **independent practice association (IPA)-model HMO**, the HMO contracts, in one of two ways, for the services of individual providers, who practice in their own offices. The IPA-model HMO may contract directly with the individual provider, who agrees to provide covered services to enrollees of the HMO, or the HMO may contract with a legal entity established for purposes of negotiating with the HMO on behalf of individual providers, who have given that right to the legal entity. Both the IPA-model HMO and the legal entity are referred to as IPAs. The individual provider agrees to follow the practices and procedures of the IPA-model HMO in providing covered services to the enrollees of the HMO. In general, the greater the percentage of a provider's practice that is made up of a particular HMO's enrollees, the greater the compliance with those practices and procedures. The provider is free to contract with other HMOs and to maintain fee-for-service patients.
- A **point-of-service (POS) option** may be offered by any model type of HMO. Under a POS option, the consumer may choose to obtain covered services from providers either within or outside the HMO's network. A consumer who chooses to obtain services outside the network generally must pay a greater portion of the cost for a covered service.

**Utilization review,** a process of analysis of the care provided to individual consumers, has been used extensively in both fee-for-service indemnity and prepaid health-care arrangements. It is aimed both at improving the quality and decreasing the cost of health care.

In addition to individual consumers, providers, and insurers, the fourth important entity in the financing and delivery of health care is the **purchaser** of health insurance. Purchasers include individuals, employers, and governments at all levels. Employers and governments, because they purchase care for large numbers of people, can influence the development of benefits packages, including preventive services. In addition, these large purchasers can bargain for lower prices and ensure that systems are in place to monitor the access to, quality of, and satisfaction with care.

## THE RELATIONSHIP BETWEEN MANAGED CARE AND PREVENTION

The rapid, extensive changes in the health-care system in the United States provide public health agencies with new opportunities for prevention-oriented relationships

with the private health-care system (*1*). HMOs can play a powerful role in prevention for at least three reasons.

First, HMOs are rapidly becoming a major source of health care for the beneficiaries both of employer-funded care and of the publicly funded programs, Medicaid and Medicare. Enrollment in HMOs in the United States has grown from 6 million persons in 1976 to 51 million in 1994 (*2*). Enrollment grew by 11% in 1994 alone (*2*). This increase in managed care has been greatest in health insurance funded by employers. In 1994, only 37% of persons employed by organizations with ≥10 employees remained in traditional fee-for-service indemnity plans; 23% were enrolled in HMOs (*3*). For employers with >500 employees, health-care costs declined in 1994 for the first time in a decade; this decrease resulted almost entirely from a shift of health insurance from traditional fee-for-service indemnity plans to less costly managed care plans (*3*).

State governments also are converting to managed care for their Medicaid programs, which provide care to the poor and disabled (*4*). States have been particularly concerned about Medicaid beneficiaries' lack of access to primary-care providers and their overreliance on emergency room care, which lacks continuity and is expensive (*5*). In June 1994, 43 states, the District of Columbia, and Puerto Rico reported having at least one managed care program for Medicaid recipients (*5*). As of that date, 7.8 million (23%) Medicaid beneficiaries were enrolled in managed care, compared with 14% in 1993. Generally, states have established Medicaid managed care programs by obtaining one of two types of waivers from HCFA: Section 1915(b) freedom-of-choice waivers, which are generally restricted geographically, and Section 1115 research-and-demonstration waivers, which are statewide. Although interest in Section 1115 waivers has grown recently, 1915(b) waivers are more common: 38 states and the District of Columbia had 1915(b) waivers in October 1994 (*5*). The nature of the managed care arrangements under these waivers varies, from fee-for-service primary care case management (31% of enrollees in 1994) to fully capitated HMOs (51% of enrollees in 1994) (*5*). To date, Medicare beneficiaries, who are predominantly adults ≥65 years of age, have been less likely to enroll in HMOs; however, in this age group, enrollment is also growing rapidly. As of December 1994, 9% of Medicare beneficiaries were enrolled in managed care. The majority, 7% of beneficiaries, were enrolled in fully capitated "risk" HMOs, and this proportion increased by 25% from 1993 to 1994 (*6*).

Second, HMOs historically have included prevention, and they maintain and continue to develop systems to measure performance and improve quality of services, including preventive services. Many HMOs use internal performance-measurement and quality-improvement systems such as Continuous Quality Improvement (CQI) to monitor, correct, and enhance their services. External systems of measurement and improvement are also imposed on the HMOs. One of these is the "report card," a set of measurements that an HMO uses to evaluate the quality of the service and care it provides. The best known of these "report cards" is the Health Plan Employer Data and Information Set (HEDIS) (*7*), developed jointly by HMOs, purchasers, and consumers under the guidance of the National Committee for Quality Assurance, an accrediting organization for HMOs. Of the nine indicators of quality-of-care in the most recent version of HEDIS (version 2.5), seven are preventive (*8*). These indicators include the incidence of low-birth-weight infants among the HMOs' enrolled

populations and their utilization of vaccinations, mammography, screening for cervical cancer and cholesterol, prenatal care, and retina examinations for persons with diabetes.

Third, HMOs represent organized care systems that take responsibility for defined populations and are accountable to purchasers, individual consumers, and federal and state regulatory agencies for desired outcomes, including prevention outcomes. Many HMOs provide or are developing systems that promote and deliver preventive services rather than relying on individual providers, and the HMOs can be held accountable for the delivery of these services. In a recent study of Medicare beneficiaries enrolled in HMOs and traditional fee-for-service systems, cancers of the breast, cervix, and colon, as well as melanoma, were detected at earlier stages in the HMO enrollees (*9*). The cancers detected earlier were those for which screening and early detection are beneficial, and the authors attributed the earlier detection to HMO systems for screening. On the other hand, a recent review of the literature on Medicaid managed care indicates that, in most states, the delivery of preventive services neither increased nor decreased for Medicaid recipients after they were enrolled in a managed care plan (*5*).

The potential role of HMOs in promoting health and preventing disease is illustrated by three examples.

## Example 1

The Group Health Cooperative of Puget Sound (GHCPS) has recently summarized 20 years of its experience in primary and secondary prevention of disease (*10*). GHCPS is a large membership-governed, staff-model HMO with 486,000 members in Washington and Idaho. In 1978, GHCPS formed a Committee on Prevention and has since developed systematic approaches to programs in breast cancer screening, childhood vaccinations, influenza vaccinations for at-risk populations, smoking cessation and prevention, cholesterol screening, increased use of bicycle safety helmets by children, and detection and management of depression. Based on the Precede/Proceed Model (*11*), these programs operate at four levels: one-to-one in primary care, infrastructure, GHCPS organization, and community. The programs have demonstrated a 32% decrease in late-stage breast cancer (from 1989 to 1990); a vaccination completion rate of 89% among 2-year-old children (1994); a decrease in the prevalence of smoking in adults from 25% to 17% (from 1985 to 1994); and an increase in the prevalence of use of bicycle safety helmets among children from 4% to 48%, accompanied by a 67% decrease in bicycle-related head injuries (from 1987 to 1992) (*10*). Because several of the programs included community-wide policy interventions, the results may have extended beyond the GHCPS-enrolled population to the entire community.

## Example 2

United Health Plan, an HMO in Los Angeles, and its parent organization, the Watts Health Foundation, have recently described two prevention programs aimed at infant health (*12*). The Watts Health Foundation began in 1967 as a community health center and has served a predominantly poor population with both treatment and preventive services. The Foundation operates two divisions: United Health Plan, developed as an HMO in 1974, and a community health programs division. Of the 100,000 racially diverse members of United Health Plan, 65% are Medicaid beneficiaries, and

approximately 35% are black, 35% Hispanic, and 10% Asian American/Pacific Islander. The community health programs division operates two community health centers, a geriatric center, a school-based clinic, and several community-based health promotion programs funded by both governmental and private sources.

The recently reported infant health programs are a breast-feeding program, operated in conjunction with the Women, Infants, and Children (WIC) program, and the "Healthy Black Babies" program, designed to decrease black infant mortality through use of media and outreach to promote early prenatal care. The breast-feeding program increased the prevalence of breast-feeding among WIC mothers from 7% to 30% in 2 years. As a result of the "Healthy Black Babies" program, United Health Plan's infant mortality rate among blacks has declined from 20 to 16 deaths per thousand births during the same time period.

### Example 3

CDC's National Immunization Program and the GHAA, the HMO national trade association, have formed a nationwide alliance to improve the vaccination status of preschool children. As a result of this alliance, individual HMOs are working with public health agencies and conducting CQI initiatives in the area of immunizations. In one example, CIGNA HealthCare of Maricopa County, Arizona, a staff-model HMO with an enrollment of >205,000 members, applied the principles of CQI to increase vaccination rates in children <24 months of age.* Using the CQI process to clarify the root causes of difficulties in the process of providing immunization, CIGNA identified >40 factors that could affect achievement of their goal of 90% completion levels of the full vaccination schedule for these children. After further analysis, these factors were classified into five broad categories of intervention: data collection and patient record system; provider education; parent education; parent incentives; and public-private partnerships, community outreach, and education. Focusing the efforts of the CQI team on these five areas resulted in the standardization of vaccination records, seminars for medical staffs working with children, use of incentive coupons, and improved informational materials and programs directed at parents and caregivers. After these comprehensive changes were implemented, the vaccination completion rate for 2-year-old children enrolled in CIGNA increased from 55% in 1992 to 73% in 1994.

## WORKING GROUP'S RECOMMENDATIONS FOR CDC AND MANAGED CARE

As the nation's prevention agency, CDC is uniquely positioned to facilitate prevention practices through and with MCOs and can build on its established relationship with MCOs. For example, since 1993, CDC has worked with six HMOs with well-established health information systems to conduct research and demonstration projects on preventive services (*13*). In December 1994, CDC and the GHAA convened a conference ("Public Health Agencies and Managed Care: Partnerships for Health") (*14*), at which the approximately 150 participants from HMOs and public health agencies exchanged information and discussed future collaboration. In January 1995, CDC completed an inventory of activities with HMOs for fiscal years 1994 and 1995; the

* *Best Practices*, newsletter of the Group Health Association of America. Washington, DC: 1995, #2.

inventory identified 43 activities with a total annual funding of $17 million. In developing its recommendations for future activities, the Managed Care Working Group sought to build on CDC's base of experience and resources. The process employed by the Working Group included four stages: a) identification of assumptions about managed care; b) identification of issues—both opportunities and barriers—related to managed care and the public's health; c) development of a vision for CDC in relation to the managed care industry; and d) development of a prioritized list of recommended activities.

## Summary of Assumptions, Opportunities, and Barriers Related to Managed Care and the Public's Health

### *Assumptions*

- The health system in the United States will remain dynamic, with continuing corporate mergers and evolution in the system's organizations and their roles.
- Managed care will continue to grow rapidly as a source of care for Americans insured by Medicaid, Medicare, and employers. This growth will result in increased privatization of care for the poor and underserved.
- Managed care has provided leadership in the integration of health-care services, and increased integration can potentially increase the continuity of care.
- Because HMOs offer the capacity to both characterize and influence the services delivered to and the health status of enrolled populations, these HMOs are held accountable by purchasers, consumers, and regulators for delivering services and improving health status. This accountability is an inherent advantage of managed care.
- Health-care purchasers, particularly large employers, have collaborated with HMOs to develop external systems to measure the quality of both preventive and treatment services in managed care and to hold HMOs accountable for their delivery. Purchasers are likely to continue to be leaders in this area.
- The problem of the uninsured remains and may be increasing. The responsibility for caring for the uninsured rests with local government agencies, such as health departments and public hospitals.
- Access to needed preventive services depends on more than insurance; it also depends on provision of enabling services, such as transportation and reduction of language barriers.
- Staff of public health agencies need more practical knowledge about managed care and how it works.
- In a highly competitive health-care market, performance measurement will be important to assure that the MCOs' need to contain costs does not displace quality of care as a priority.

- Many state-level public health agencies have dual roles with HMOs, as both partners and regulators; these roles may be in conflict.
- Partnerships between MCOs and public health agencies will be particularly valuable at the local level, where health promotion and health care are delivered.
- The greatest potential for improving the health status of populations results from community-based action (e.g., reduction of risk behaviors such as tobacco use).
- Because of their clinical orientation, MCOs are more likely to be active participants in the delivery of clinical preventive services than in the delivery of nonclinical preventive services. However, MCOs can be powerful partners in nonclinical preventive service areas (e.g., education, laws, and regulations to prevent the initiation of tobacco use and to ensure environmental intervention for children with high blood-lead levels).
- MCOs have found that maintaining the health of their populations is an important way to improve their cost effectiveness.
- As MCOs have become the primary provider of health care to large segments of a community, they have become more involved with the health of the community as a whole.
- Many preventive services, even though they may be highly cost effective and may contribute to the quality of life, cost more to implement than they save. Therefore, particularly in capitated systems, additional incentives that favor investments in prevention are needed (e.g., performance measures that are prevention oriented).
- CDC has a leadership role to play in building partnerships among MCOs, purchasers, and public health agencies at all levels.

### *Issues (Opportunities)*

- Managed care organizes health care into delivery systems with potential for prevention-related surveillance, monitoring, intervention, and health services research.
- The electronic information systems of MCOs are still evolving and should be important components of any new national health information system.
- To realize the potential of health information systems, as a society, concerns about confidentiality and privacy issues and the proprietary nature of the data of MCOs must be addressed.
- Public health agencies bring valuable skills and experience to partnerships with MCOs and purchasers (e.g., experience with surveillance and information systems, epidemiologic and laboratory skills, health promotion skills, experience in developing and implementing prioritized prevention strategies, experience in using policy and legislation to promote the public's health, and experience in case

management and providing enabling services to promote access to health services for vulnerable populations).

- MCOs have the opportunity to become active leaders in promoting and protecting the health of the communities in which they are located.
- Public and private purchasers of health care, particularly large employers, HCFA, and state Medicaid agencies, have direct interest in promoting quality in managed care and could be natural partners with public health agencies in improving health outcomes.
- HEDIS, its future iterations, and other measures of quality of care can provide a strong incentive for prevention.
- Public health agencies have the opportunity to define their roles in the largely reorganized health system.
- Partnerships among MCOs and public health agencies will require all entities involved to augment skills through continuing education and training.

### *Issues (Barriers)*

- As Medicaid beneficiaries convert to managed care arrangements and no longer receive care from local health departments, those health departments will lose the Medicaid reimbursement that has helped subsidize care for the uninsured. As a result, fewer resources may be available with which to care for the uninsured.
- Some local health departments are electing to become part of an HMO and compete with other HMOs in the delivery of health care. This competition may affect their ability to form partnerships with HMOs.

### *Vision*

CDC's existing vision statement, "Healthy people in a healthy world through prevention," needs no modification. The challenge to public health agencies is to work with MCOs, providers, purchasers, and consumers to make this vision a reality.

## Recommended High Priority Activities for CDC

### *Prevention Effectiveness and Guidelines*

Work with MCOs, purchasers, and state and local health departments in key areas of prevention effectiveness, including

- using information to determine the prevalence, incidence, and burden of disease, and the availability, efficacy, acceptability, effectiveness, and cost-effectiveness of interventions to specify highest-priority health problems for prevention;
- assessing, through original research or review of the scientific literature, the effectiveness and cost-effectiveness of population-based and clinical strategies for prevention; and

- developing, disseminating, and evaluating a "Guide to Community Preventive Health Services," science-based recommendations for choosing and implementing community-based preventive services.

### *Medicaid and Managed Care*

CDC will collaborate with states, MCOs, and HCFA to design and implement Medicaid managed care arrangements that specify cost-effective preventive services for Medicaid populations and hold all managed care plans accountable for the delivery of these services. Examples of activities include

- developing models to allow state Medicaid agencies to contract with MCOs for highest-priority preventive services and to specify essential services that occur outside the clinical environment to protect the public (e.g., tracing contacts of persons with communicable diseases) and
- developing priority—including primary—prevention indicators for use in monitoring the performance of managed care plans.

### *Research*

As several populations in the United States, including the Medicaid population, convert to managed care, CDC will undertake research to document the health effects of the reorganized systems that deliver preventive services. Examples of research topics include

- comparing the site and quality of treatment of sexually transmitted diseases (STD) in a state where STD treatment was included in the Medicaid capitation with those in a state where funding was maintained for STD treatment in public clinics,
- assessing the adequacy of follow-up for Medicaid-eligible children with elevated blood-lead levels, before and after implementation of Medicaid managed care, and
- assessing the quality of occupational health services provided by MCOs.

### *Capacity Development in Public Health Agencies*

As underserved populations are enrolled in managed care, bring MCOs and public health agencies together on common issues and help to refine the role of public health agencies. Examples include

- preventing pregnancy among adolescents in a community, jointly assigning responsibilities for clinical and community-based activities among MCOs, the school system, voluntary organizations, and the health department;
- developing community-wide strategies to increase bicycle helmet use; and
- developing community-wide registries to facilitate childhood immunization.

Enhance and develop capabilities within health departments and CDC in prevention-related areas critical to partnership with and regulation of MCOs.

Examples include community needs assessment, coalition-building, quality assurance, utilization management, and health services research and evaluation.

## Recommended Priority Activities for CDC

### *Information Systems*

Collaborate with MCOs and state and local health departments to standardize and improve their information systems so that these systems can be used for community-wide health assessment and surveillance of notifiable conditions, health determinants, and risk factors. Examples include

- modifying a state's Behavioral Risk Factor Surveillance System so that, in addition to providing population-wide data on HIV risk and prevention behaviors, it provides information to individual HMOs on their member populations;
- using MCO infectious disease laboratory data systems for notifiable disease surveillance for the MCO population; and
- developing model public health surveillance and information systems that utilize electronic consumer records and insurance billing information.

### *Quality Assurance*

Assist in developing measures and other systems to monitor and ensure the quality of preventive services delivered by all providers. Examples include

- working with employers on prevention requirements in contracts with HMOs and
- working with the National Committee for Quality Assurance to include a measure of tobacco use on future versions of HEDIS.

### *Partnerships*

Continue to build partnerships and mutual understanding among CDC, public health departments, MCOs, and purchasers through activities such as

- staff exchanges, including assignment of epidemiologists to HMOs;
- mutual representation at conferences of public health interest;
- technical assistance in areas such as immunization registries;
- evaluation of the implementation of *Putting Prevention Into Practice* (*14*); and
- joint advocacy for public health priorities, such as enforcement of laws to prevent tobacco purchases by minors.

## Conclusion

In summary, the continuing evolution of the health-care system in the United States provides new opportunities for partnerships among MCOs, purchasers of health care, and public health agencies to foster prevention in the private health-care system. CDC has a key leadership role to play in this area, and its Managed Care

Working Group has, in consultation with a broad spectrum of leaders in health care and public health, recommended a list of prioritized activities for CDC. As one of its first steps in implementing these recommended activities, CDC has designated a Managed Care Coordinator in the CDC Office of the Director. Readers who are interested in more information about CDC's activities related to managed care and prevention may call the Managed Care Coordinator's office at (404) 639-4500.

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