

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PUBLIC HEALTH AND
MANAGED CARE**

OPPORTUNITIES FOR COLLABORATION



**JUNE GIBBS BROWN
Inspector General**

**JULY 1999
OEI-01-98-00170**

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them. This statutory mission is carried out through a nationwide program of audits, investigations, inspections, sanctions, and fraud alerts. The Inspector General informs the Secretary of program and management problems and recommends legislative, regulatory, and operational approaches to correct them.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) is one of several components of the Office of Inspector General. It conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The inspection reports provide findings and recommendations on the efficiency, vulnerability, and effectiveness of departmental programs.

OEI's Boston Office prepared this report under the direction of Mark R. Yessian, Ph.D., Regional Inspector General. Principal OEI staff included:

REGION

Russell W. Hereford, Ph.D., *Project Leader*
Nicola Y. Pinson

HEADQUARTERS

Elise Stein, *Program Specialist*

To obtain copies of this report, please call the Boston Regional Office at (617) 565-1050
Reports are also available on the World Wide Web at our home page address:

<http://www.dhhs.gov/progorg/oei>

EXECUTIVE SUMMARY

PURPOSE

To assess how State public health agencies are taking advantage of opportunities for collaboration with managed care plans to further population-based health activities.

BACKGROUND

State and local public health agencies carry out a fundamental government responsibility to protect the health of the population. They track disease, intervene in communities to control exposures that threaten the population, and respond to changes in communities' health needs.

Increasing portions of privately and publicly insured populations are enrolled in managed care plans. As organized systems of care that are increasingly data-driven, managed care plans offer public health agencies opportunities to track disease and health trends and to mount effective interventions.

The Department of Health and Human Services has recognized the important influence of managed care across many operating divisions. Within the Department, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Health Care Financing Administration have initiatives that directly address the impact of managed care on public health programs within their purview.

This inspection utilizes the results of a national survey of State health officers and intensive interviews with State and local public health officials to obtain an overview of activities that are taking place in this field.

FINDINGS

States are giving increased attention to fostering collaborations between public health departments and managed care organizations.

Public health officials in 16 of 47 States responding to our survey reported that their State requires managed care organizations to collaborate with public health departments.

Because collaborations are very recent, measurable accomplishments to date are limited. Yet, all 16 of these State officials indicated that they plan to continue the collaborations.

Despite the absence of State law or regulations, another 27 States reported that some collaborations are taking place between managed care plans and public health departments.

Collaborations focus predominantly on delivering services, rather than on population-based public health activities.

The majority of States reported that collaborations focus on delivering direct personal and medical services to Medicaid eligible individuals enrolled in managed care plans.

Very few States reported collaborations that link clinical activities of managed care organizations with population-based functions that are the responsibility of public health departments.

We identified three major areas of challenge that confront collaborations to further public health population-based functions.

Although there is a conceptual alignment between managed care and public health concepts of prevention-oriented health services, managed care goals do not translate easily into public health goals.

Managed care operational decisions and activities are affected by multiple stakeholders, such as medical providers and private health care purchasers. Yet, these groups are largely absent in planning and implementing the collaborations.

Despite the potential role that clinical data from managed care plans could play to enhance public health activities, States reported extensive obstacles that hinder data sharing.

CONCLUSION

Based on the findings of our study, we come to one central conclusion: Collaborations that address public health population-based strategies have barely begun. In fact, the current environment may mean that opportunities for realizing the potential of collaboration are fading.

We draw this conclusion from elements we identified in our findings, including the traditional isolation between the medical and public health sectors; limited participation among key stakeholders; and the resources needed to coordinate data systems and collection. In addition, the situation looks even less promising when one considers constraints such as the highly competitive market among managed care organizations and their increasing reliance on decentralized network models to deliver services.

OPPORTUNITIES FOR IMPROVEMENT

Given these constraints, constructive movement toward collaborations to further essential public health population-based activities is hard pressed based on good will efforts alone. Because regulation of managed care plans occurs for the most part at the State level, the Federal role in encouraging MCOs to invest in broad population-based activities is limited. But the Department of Health and Human Services can exert an important leadership role by encouraging collaboration under its existing authorities.

To be sure, components within the Department have begun to coordinate their managed care and public health activities. For example, HCFA, HRSA, and CDC have recently signed a formal interagency agreement to support data sharing between State Medicaid and public health agencies. These agencies also have supported the development of contract specifications that provide guidance on purchasing services such as immunizations, tuberculosis, lead paint poisoning, and HIV/AIDS.

Toward this goal, and with this progress in mind, we offer some options for consideration.

- ▶ The Centers for Disease Control and Prevention could incorporate into its program announcements and guidance specific language pertaining to coordination of public health and managed care activities, including data sharing, where appropriate.
- ▶ The Health Care Financing Administration could encourage States to require that managed care plans contracting with Medicaid specify how they will work with State and local health agencies to identify and achieve public health goals; encourage State Medicaid programs to examine sample purchasing specifications as they prepare contracts with managed care providers; and encourage managed care plans to share HEDIS or other appropriate data with State public health departments in order to enhance their surveillance function.
- ▶ The Health Resources and Services Administration could work with organizations, such as community health centers and Ryan White CARE Act-funded providers, that participate in managed care networks to help these providers exchange data with the State public health departments. The agency also could foster collaborations by encouraging its field units in the Department's Regional Offices to work proactively with the States to initiate collaborative activity with managed care organizations.

COMMENTS ON THE DRAFT REPORT

Within the Department, we received written comments on the draft report from CDC, HCFA, and HRSA. We also received comments from the Association of State and Territorial Health Officials. Here, we summarize these comments and our response. We have also made a number of editorial and technical changes in the report.

Centers for Disease Control and Prevention (CDC)

The CDC generally agrees with our report, but asks that we clarify wording regarding the emphasis it might place upon activities it funds. We have adopted, with minor modification, the CDC's recommended language because it provides additional specificity to further the intent of actions we suggested.

The CDC also raises concerns that our conclusion is too negative. We based this conclusion on evidence we found — the limited extent and scope of collaborative efforts, and the formidable constraints that confront them.

Health Care Financing Administration (HCFA)

The HCFA concurs with the opportunities for improvement we identified. The HCFA questions whether it should require Medicaid plans to share HEDIS data with public health agencies. We believe that HCFA could exert leverage for further collaboration by requiring the sharing of such data. We modified language to address HCFA's concern.

The HCFA also asks us to seek input of State Medicaid directors. We carefully weighed such a survey, but opted to focus on public health departments in order to find collaboration occurring among private sector, as well as in Medicaid managed care plans.

Health Resources and Services Administration (HRSA)

The HRSA asks that we replace our suggestion that HRSA require States to provide information on linkages with language to encourage the development of voluntary reporting measures on such linkages. In response, we modified the report to address HRSA's concern. Such information would provide HRSA with a baseline from which the agency could develop technical assistance, training, information dissemination, and evaluation efforts through its Center for Managed Care.

Association of State and Territorial Health Officials (ASTHO)

The ASTHO raises concerns that our report does not adequately reflect the work regarding collaborations that focus on service delivery. We do not diminish the importance of these services. Rather, this report focuses on population-based activities.

The ASTHO indicates that, while it may be true that State and local public health officials are missing out on opportunities, our report seems to indicate that the problem lies solely with health departments. We do not ascribe blame to any sector. Our text indicates the challenges that confront both the public health and managed care sectors.

TABLE OF CONTENTS

	PAGE
EXECUTIVE SUMMARY	1
INTRODUCTION	6
FINDINGS	
Collaborations Increasing	9
Few Population-Based Activities	11
Obstacles to Collaboration	14
CONCLUSION	17
OPPORTUNITIES FOR IMPROVEMENT	18
COMMENTS ON THE DRAFT REPORT	21
APPENDICES	
A: Text of Comments on the Draft Report	24
B: Frequency Responses to Mail Survey	36
C: Endnotes	45

INTRODUCTION

PURPOSE

To assess how State public health agencies are taking advantage of opportunities for collaboration with managed care plans to further population-based health activities.

BACKGROUND

Public Health Population-Based Functions

State and local public health agencies carry out a fundamental government responsibility to protect the health of the population at large. This public health responsibility relies on population-wide surveillance systems that provide basic information for public health officials to track and trace disease within communities, intervene in communities and control exposures that are threats to the population, and develop appropriate policies and programs that respond to the changes in health status and health needs of communities.

Over the past several decades, public health departments have also taken on a role in providing medical care to low-income and uninsured populations. As States shift increasing portions of Medicaid and low-income populations into private managed care plans, the role of public health agencies is also changing. In many States, public health agencies are lessening their role in the provision of clinical services, and turning increased focus toward population-wide strategies that make communities a healthier place to live.

Opportunities for Collaboration with Managed Care Organizations

Public health agencies and managed care organizations (MCOs) have the potential to combine efforts to pursue activities that neither system can do alone. With timely and accurate data from managed care organizations, public health agencies can identify changes and trends in key health indicators, and mount effective interventions. In turn, managed care organizations can benefit from effective public health population-based practices that prevent medical problems. The Institute of Medicine recently reported, “If the proper kind of partnerships between managed care organizations and government public health departments are developed, managed care can indeed make an important contribution to improving the health of the public.”¹

We identified five key characteristics of managed care plans that present a unique opportunity for public health agencies in pursuing population-based strategies:

1. Managed care organizations are responsible for providing health care services to increasing numbers of both privately and publicly insured populations. State governments are using managed care for most or all of their Medicaid programs.
2. Managed care organizations and public health departments share interests in prevention-oriented activities. Under a capitated system, MCOs have financial incentive to support public health prevention activities in order to reduce cost of expensive medical interventions.
3. Managed care organizations represent organized care systems that focus on defined populations. In contrast to loosely integrated individual providers and patients in the fee-for-service system, managed care systems offer a more consolidated potential for communication with the public health system.
4. Health care services and quality in managed care plans are increasingly data driven, offering public health opportunities to track disease and health trends among communities. Managed care plans maintain and continue to develop data systems to measure performance and improve quality of services; States are also employing external systems of measurement (*e.g.*, HEDIS 3.0). These systems could provide timely and accurate data that are necessary for public health to mount effective interventions.
5. Managed care organizes individual physicians into larger networks and may sponsor continuing education, practice guidelines, and other influences over physician practices.

The Federal Interest in Fostering Collaboration

The Department has recognized the important influence of managed care across many operating divisions. The Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Health Care Financing Administration all have initiatives that directly address the impact of managed care on public health programs within their purview.

The new Strategic Plan for the Department notes that “the shift to managed care heralds a changing role for health agencies, especially the opportunity to concentrate on providing a full range of essential public health services.”²

The Centers for Disease Control and Prevention (CDC) maintains a particular interest in ensuring that data collection and disease surveillance systems are operating effectively to ensure the health of the public. The CDC has supported several grants to strengthen State public health infrastructures and improve the integration of information systems. These include, for example, the CDC Assessment Initiative and the CDC Information Network

for Public Health Officials (INPHO) grant.

The Health Resources and Services Administration (HRSA) established a Center for Managed Care in 1996 to provide technical assistance, training, information dissemination, and evaluation on managed care issues that cross all of HRSA's programs. "The Center is responsible for assuring that HRSA's programs and the underserved and vulnerable populations they serve are active and knowledgeable participants in managed care systems."³

The Health Care Financing Administration (HCFA) has supported the development of managed care for beneficiaries in both the Medicaid and Medicare programs. The intersection between Medicaid managed care and public health agencies is of particular note in specifying coordination of essential public health services that occur outside the clinical environment. In addition, public health agencies can play a role in developing quality indicators to monitor the performance of plans.

METHODOLOGY AND SCOPE

The intent of this inquiry is to provide a national overview of the extent to which State public health departments are pursuing collaborative opportunities with managed care organizations. We focus on an assessment of the extent and overall nature of these relationships, excluding attention to specific details of individual case studies.

Data collection for this inspection comprises three parts: 1.) A national mail survey of State Health Officers conducted in June 1998. We focused on State Health Officers because we determined that the State Health Department would be in the best position to know about population-based public health activities; 2.) Structured follow-up telephone interviews with State and local public health officials to obtain a more in-depth understanding of the activities that are taking place in this field. We also conducted structured interviews with several representatives of the managed care sector; 3.) An intensive site visit to Minnesota, a State with legislatively mandated collaboration between managed care plans and the public health community.

FINDINGS

States are giving increased attention to fostering collaborations between public health departments and managed care organizations.

Public health departments in 16 of 47 States responding to our survey reported that their State requires managed care organizations to collaborate in some way with public health departments.

Within the last several years, States have established a range of requirements that encourage collaborative activities between public health departments and managed care organizations. Six of the 16 States require all managed care organizations to collaborate with local or State public health departments. Twelve States require collaboration in their Medicaid managed care contracts. Two States require collaboration in both the Medicaid contract, as well as more broadly among all MCOs.

Minnesota and New York, for example, require all State-regulated MCOs to collaborate with local health departments. In Minnesota, State law requires MCOs to develop collaboration plans in conjunction with local health departments. Each MCO must submit collaboration plan documents biennially to the Minnesota Department of Health. These documents describe how the MCO will work with local or State public health departments toward achieving public health goals. In New York, the Department of Health requires MCOs to coordinate specific public health related services, such as communicable disease control, with local public health departments.

The majority of the 16 States require collaboration in the Medicaid contract with MCOs. We identified two ways that States require collaboration in Medicaid contracts. First, most contracts require MCOs to reimburse public health departments for delivering specific services to enrollees. These include services that public health department traditionally provided for Medicaid clients, such as immunizations, family planning, prenatal and postnatal care, and STD services. Second, some contracts require coordination between clinical services and population-based public health services. For example, the Michigan Medicaid contract developed a detailed matrix that specifies essential roles for the State health department, local health departments, and MCOs regarding eight services provided by MCOs, such as services for communicable disease and lead poisoning.

In addition to the 16 States with formal requirements, another 9 States indicated that they are very likely to establish collaborations in the next 2 years. Texas, for example, will

implement requirements for formal agreements between local health departments and MCOs in two regions of the State by 1999.

Because collaborations are very recent, measurable accomplishments to date are limited. Yet, all 16 of these State officials indicated that they plan to continue the collaborations.

Very few States employ specific performance measures to evaluate their collaborative activity or progress. Some States reported plans to gauge their collaborative impact through HEDIS or other MCO quality performance measures. Yet overall, States reported, as one State health department summarized, “future goals to explore more specific data and measurement issues, including building a set of common indicators or standards to evaluate the effectiveness of collaborative efforts.” Most of these 16 States reported progress in developing relationships between MCOs and public health departments as their most significant accomplishments to date.

States described future expectations to strengthen linkages between the clinical activities of managed care organizations and population-based functions of public health departments. These expectations include collaborations that would strengthen public health surveillance systems to track and trace disease in communities, conduct appropriate environmental interventions, identify community health needs and gaps in services, and use data in planning and policy development.

Despite the absence of State law or regulations, another 27 States reported that some collaborations are taking place between managed care plans and public health departments.

Several voluntary initiatives underway reflect a growing awareness on the part of both the public health and the managed care sectors of mutual benefits to be gained from working with each other. Many communities are getting together without auspices of formal requirements.

As an example of an innovative collaborative initiative, the HHS Regional Director’s Office in New England has initiated a Public Health/ Managed Care Collaborative Initiative. Public health officials and managed care representatives in the six New England states (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut) are discussing collaborative opportunities in areas of asthma detection and prevention, tobacco control, and improving childhood immunization rates.

Collaborations focus predominantly on delivering personal health and medical care services. Collaborations that address population-based public health activities are much less common.

The majority of States reported that collaborations focus on delivering direct personal and medical services to Medicaid eligible individuals enrolled in managed care plans.

Twelve of the 16 States reported that collaborations focus activity on direct-care services. The Medicaid managed care contract serves as the primary vehicle for most of these collaborations. Some States encourage health departments to become a part of the managed care plan's network of providers. Other States require health plans to reimburse local health departments for delivering certain services.

We identified two primary activities that comprise the direct-care services that collaborations address. First, States reported collaborations that focus on direct medical services that local health departments have traditionally provided to Medicaid clients. These include services for communicable diseases, clinical preventive services, and primary care services. For example, Colorado law requires Medicaid MCOs to contract with local health departments for direct care services. Oregon requires contracts between Medicaid managed care plans and local health departments in order to specify how reimbursement will occur for STDs, TB, and family planning services.

Second, State health departments reported significant activity in providing direct care services that complement medical services delivered to Medicaid populations. For example, New Mexico's three Medicaid MCOs contract with the Department of Health for the Department to offer and provide prenatal and infant/child case management services to eligible pregnant women. In Tennessee, local health departments provide outreach, education, and case management services to Medicaid clients enrolled in managed care plans.

We heard three primary reasons that States give priority to arrangements around the delivery of direct-care services. First, the public health system has built considerable expertise over the past several decades in addressing obstacles that Medicaid populations face in accessing medical services. Twelve States reported significant concern within the public health community about losing their role in service delivery to managed care organizations. Repeatedly, public health officials expressed concern over the ability of managed care organizations to meet the diverse set of needs of Medicaid clients, that are often not apparent in delivering services to their commercial populations.

Second, reimbursements from managed care organizations for direct care services allow public health departments to continue their clinical and direct care programs. Over the

past several decades, Medicaid reimbursements for direct care services have been significant sources of revenue supporting several types public health programs and functions. With major shifts of Medicaid populations into managed care plans, these funding streams have also shifted, confronting the public health system with significant losses in revenue. Health departments also expressed concern that the complete absence of clinical services from their programs will not allow them resources to provide services to the uninsured or homeless, functions which the public health community views as a fundamental responsibility.

Third, health departments reported concern over health services delivered through managed care organizations that are especially dependent upon coordination between clinical and population-based activities. For example, if a managed care organization identifies and treats an enrollee with a sexually transmitted disease, how should the MCO coordinate follow-up STD contact tracing? Who is responsible for treating partner-contacts who are not a part of the MCO enrolled population?

Very few States reported collaborative activities that link the clinical activities of managed care organizations with population-based functions that are the unique responsibility and authority of public health departments.

Because MCOs are organized systems of medical care for defined populations, the medical information and data that they maintain could greatly strengthen public health department surveillance systems to facilitate activities that protect the health of the population at-large. These activities include tracking and tracing disease in communities, identifying community health needs, identifying emerging public health issues, and activating appropriate community interventions.

However, based on our survey, States reported few collaborative activities that are taking routine advantage of clinical information from MCOs to perform essential public health population-based functions. Only four States reported that their collaborations involve sharing disease incidence data; six States reported sharing reportable disease data; and only two States reported sharing environmental exposure data. None of the States indicated collaborative activity that facilitates public health environmental interventions based on managed care clinical information.

States reported slightly more collaborative activity that increases managed care involvement in communities beyond their enrolled populations. For example, six States reported collaborative activity in health education campaigns; and eight States indicated activity in planning and policy development. Overall, however, these activities are not based on data that systematically identify community health needs. One managed care representative summarized these activities as “the philanthropic side of managed care that fits into their ‘community benefit’ activities, but does not affect their core business operations, such as medical practices and medical data.”

The potential of linkages between managed care clinical activities and essential public health functions can be seen in efforts underway in a few States. For example, New York and Michigan use guidelines to facilitate coordination between managed care clinical activities and public health population-based functions. The guidelines specify essential responsibilities of managed care organizations and public health departments for specific issues of public health importance. These essential activities include, for example, delivering medical services, conducting appropriate follow-up or environmental interventions, reporting disease incidence, conducting disease surveillance, coordinating community resources, and developing educational materials. Public health issues addressed include communicable disease control, STDs, HIV/AIDS, TB, cancer, diabetes, lead poisoning, rabies, and immunizations.

Oregon also reported collaborative activity intersecting managed care clinical and public health population-based functions. The Department of Health has initiated a Managed Care/ Public Health Assessment Initiative, which requires managed care organizations to share encounter data on their Medicaid populations. Data from this initiative are being analyzed to pinpoint incidence and prevalence of diabetes and breast cancer among Medicaid beneficiaries.

Five States also indicated collaborative activity to develop population-based data registries. Generally, these registries involve the centralized collection of immunization data. As an example of a promising activity in this regard, Missouri has developed a state-wide central immunization registry that is planned as part of a larger integrated information system of all public health functions. The project has attracted active managed care participation and interest. One public health department official explained, “because populations are constantly moving in and out of MCOs, they see a particular advantage to accessing immunization histories for current and new enrollees.”

Both the Oregon and Missouri projects are supported in part through a CDC grant to facilitate development of integrated State information systems.

We identified three major areas of challenge that confront collaborations to support public health population-based functions.

Although there is a conceptual alignment between managed care and public health concepts of prevention-oriented health services for defined populations, the managed care goals do not easily translate into public health goals.

We heard three fundamental differences that it make it difficult to establish managed care-public health relationships.

First, the two sectors have traditionally operated in isolation from each other; they often have minimal understanding of what the other does and how these activities might intersect in collaborative work that truly benefits both partners. Thirteen States indicated a lack of awareness within the managed care community of public health activities as a significant obstacle hindering collaboration. Nine States indicated in our survey that lack of knowledge about managed care posed significant obstacle to collaboration.

We heard several examples that demonstrate the isolation of both sectors. First, managed care organizations commonly do not understand the population-based functions conducted by public health departments. One expert identified common managed care perceptions of public health departments as synonymous with the Medicaid agency, or “public” providers of health care services. In addition, managed care representatives often understand public health activities as preventive clinical services for populations of people. In sum, MCOs do not recognize how they can contribute to a unique role for public health departments that extends beyond the MCO’s own capacity and authority.

We also heard repeated comments that public health is not abreast of managed care market environment, which inhibits efforts to coordinate and communicate effectively. One expert told us that, “Public health likes to think of managed care organizations as the old staff-model HMO.” In reality, managed care organizations represent a variety of rapidly evolving prepaid health care systems, ranging from non-profit to for-profit entities, and from tightly managed staff model systems, to relatively loose configurations of provider networks.

Second, there are very different financial incentives between the two cultures. Eleven States reported a general distrust of managed care plans as a significant obstacle; managed care expressed frustration with lack of public health appreciation for managed care cost considerations. MCOs are operating in a competitive business environment, where short-term cost savings are paramount. Operational activities and decisions are based on a narrow analysis of the cost and benefits of health care services provided to their enrolled populations. Any expansion of benefits means an increased premium that must be paid by

enrollees and affects their financial bottom line. Public health departments, on the other hand, are carrying out broad-based social responsibility to ensure the health of the public at-large. It is often difficult to measure the significance of these activities in a narrow cost-benefit analysis. In addition, because public health activities are paid for through governmental revenues, the actual costs are much more diffuse. One managed care representative summarized differences, “Public health has a fundamental charge to reduce human suffering and disease for the population at-large. Health plans are charged with how to pay for specific health care services for their enrolled populations.”

Third, States reported obstacles to communication between the two sectors. For example, organizational vocabularies demonstrate fundamental differences. We heard one example in the way public health and managed care communities understand the term “risk”. In the public health world, the term “risk” refers to health conditions that people might suffer from (*i.e.* risk of cancer). In the managed care world, the term “risk” translates into the financial burden resulting from utilization of medical services. Another example is the reference to the term “population”. Public health officials are thinking in terms of entire community or state populations. Managed care organizations focus on their enrolled populations. Finally, collaborative members reported confusion over the term “provider”. Public health officials commonly referred to the MCOs as providers; while MCOs referred to networks of medical practitioners as providers. This confusion reflected common MCO frustration with lack of public health awareness of limitations of MCO influence over provider practices.

Managed care operational decisions and activities are affected by multiple stakeholders in the health care environment, such as medical providers and health care purchasers. Yet, these groups are largely absent in planning and implementing the collaborations.

State survey responses indicated that the groups planning and implementing the collaborations are overwhelmingly composed of health departments, the Medicaid agencies, and managed care representatives. We identified three key groups that are largely absent from the collaborative planning and implementation process.

First, members of collaborative groups reported repeatedly the importance of input and involvement from medical providers. Yet, only three States reported involvement of medical providers in planning the collaborations. Ten States indicated the lack of priority of this activity among providers as a significant obstacle hindering collaborations. One member of a collaborative group summarized the absence of providers as, “There is a lot of ‘dialogue’ between MCOs and public health departments. But when the rubber hits the road, it’s at the provider level.” Managed care increasingly is evolving away from tightly integrated staff-model HMOs, yet plan representatives told us they found public health misperceptions of MCO’s ability to direct and influence provider behavior.

Second, fourteen out of the 16 States reported no or limited roles of purchasers in planning or implementing the collaborations. Yet, twelve States reported a lack of purchaser interest in supporting managed care collaborative activities with public health departments as a significant obstacle hindering collaboration. Managed care representatives repeatedly reported that the influence that purchasers exert over MCO activities is poorly understood. Repeatedly, members of collaborative groups reported the need to increase purchaser interest in the potential business benefits of public health population-based preventive functions.

Third, States reported little to no involvement of other community health-related organizations. Attention to these organizations is important to integrate the collaborative activities with existing community efforts and resources. Despite the potential role these groups might play, much of the collaborative activity has focused on managed care and public health relationships, and has not yet filtered out into broader community groups.

Despite opportunities for managed clinical data to further public health population-based activities, States reported extensive obstacles hindering activities to share data.

States identified major obstacles for sharing data that fall into three major categories.

First, eleven States indicated technical difficulties in matching data systems are an obstacle hindering collaboration. Collaborations must address the differences between public health and managed care data elements in order to use managed care data in a public health context. For example, public health collects data based on conditions, such as cancer; managed care data rest on medical services that are delivered and paid for by the MCOs, such as chemotherapy or surgeries rendered for patients with cancer.

Second, we heard about proprietary concerns for releasing data. For example, ten States indicated that managed care organizations fear that data will be used for regulatory purposes. Eleven States indicated competition among health plans hinders data sharing. One managed care representative summarized, “Even if the MCO is not against releasing the data, it needs a good reason to let data leave the plan. Otherwise releasing the data presents a potential vulnerability for competitors to use data in some competitive manner they are not yet aware of.”

Third, there are privacy issues around patient confidentiality and sharing personal medical information. Whenever personal information is released, there is a vulnerability for misuse. In some cases privacy issues present significant barriers. For example, Minnesota was unable to pass legislation for a statewide immunization registry because of an existing law barring the release of personal immunization information.

CONCLUSION

Significant attention has focused recently on opportunities for collaboration between managed care organizations and public health departments: potential for comprehensive approaches that intersect the patient-oriented practice of medicine and the population-based strategies of public health. As organized, data-driven systems of medical care delivery, MCOs could facilitate health departments' ability to track disease, identify outbreaks, and implement effective interventions that meet communities' needs.

Based on the findings of our study, however, we come to one central conclusion: Collaborations that address public health population-based strategies have barely begun.

When we began this study we expected to find numerous examples of how health departments are working with MCOs to obtain information that assists them in carrying out their responsibility for the health of the population at large. To date, however, most collaborations have focused on arrangements for delivering services to individuals, not on population-based public health. We recognize the vital public health importance of medical care services, but we focus our attention here toward population-based activities.⁴

Despite conceptual links between the two sectors' activities, our report identifies significant constraints that inhibit these types of collaborations.

- ▶ **Isolation.** Traditional isolation between the medical and public health sectors compounds the odds against productive areas of collaboration that recognize the essential and unique roles of each sector.
- ▶ **Limited stakeholder participation.** Limited involvement of health care providers and purchasers narrows the base of support needed for MCOs' partnership in public health population-based practices.
- ▶ **Data challenges.** Demands for time, money, and other resources challenge the ability to coordinate data systems and collection.

In fact, the current environment may mean that opportunities for collaboration are fading.

- ▶ **Competition.** The MCO market is highly competitive. Performing a broad-based community function reaching beyond the enrolled population is unlikely where the short-term bottom line is paramount, unless all plans make the same contribution.
- ▶ **Growth of networks.** The evolution of managed care toward decentralized network models further erodes the potential for collaboration with organized systems of care.

OPPORTUNITIES FOR IMPROVEMENT

Given these constraints, constructive movement toward collaborations to further essential public health population-based activities is hard pressed based on good will efforts alone. Because regulation of managed care plans occurs for the most part at the State level, the Federal role in encouraging MCOs to invest in broad population-based activities is limited.

The Department of Health and Human Services can exert an important leadership role by encouraging collaboration under its existing authorities. Because many Departmental activities cut across individual agency lines, fostering interagency coordination and collaboration will be critical. To be sure, components within the Department have begun to coordinate their managed care and public health activities. For example, HCFA, HRSA, and CDC have recently signed a formal interagency agreement to support data sharing between State Medicaid and public health agencies.

Another important step toward collaboration is the development of sample purchasing specification language for use by State Medicaid offices when they contract with managed care plans. These purchasing specifications were developed by the George Washington University Center for Health Policy Research, under contract with HRSA and CDC and with input from HCFA. The specifications provide a base structure to establish and negotiate collaboration among public health agencies, purchasers of publicly-funded health services, and managed care plans. Additionally, the specifications address public health issues, quality assurance, data collection and sharing, memoranda of understanding, surveillance, and information systems.

Toward this goal, and with this progress in mind, we offer some options for consideration. Agencies within the Department could adapt these to further enhance the coordination and collaboration between managed care and public health.

- ▶ **The Centers for Disease Control and Prevention** could place emphasis in the appropriate activities it funds on projects that focus on integrating the data and communications infrastructure and improving data sharing between public health departments, Medicaid agencies, and managed care organizations. The CDC already supports some collaborative activities. Among the State collaborations we examined, Minnesota, Oregon, and Missouri identified support from CDC's Assessment Initiative, a cooperative agreement program intended to help States improve data coordination and integration as a way of developing information for improved policy making. Missouri noted that it also is receiving CDC support under the Information Network for Public Health Officials (INPHO) project, designed to assist States to develop the infrastructure and support needed for effective information and

surveillance systems. As it awards future funding under these authorities, the CDC might wish to pay particular attention to projects that help State public health departments determine how they can work with organized delivery systems to design information systems that enhance their capacity and ability to share surveillance data.

The CDC also could require States to submit information on the extent to which the programs the agency funds work with managed care organizations. For example, the CDC might require States to document the extent of MCO reporting to communicable disease or cancer registries.

- ▶ **The Health Care Financing Administration** could encourage collaboration by developing guidance for States on the kinds of public health activities that might be included in Medicaid managed care contracts. For example, the HCFA might encourage States to require that managed care plans contracting with Medicaid specify how they will work with State and local health agencies to identify public health goals, and how they will work with the agencies to achieve these goals.

The HCFA also might provide specific guidance to States on guidelines that could be communicated to health plans. For example, the sample purchasing specifications noted previously could be used by State Medicaid programs as a tool to help identify key issues and decision points as they prepare their purchasing agreements for services such as immunization and lead poisoning screening, prevention, and treatment. The HCFA could encourage States to review and consider the appropriateness of these specifications, and how they could be adapted to the unique needs of each State's Medicaid program. The sample purchasing specifications may be found at <http://www.gwumc.edu/chpr>.

The HCFA could also encourage managed care plans, both Medicaid and or Medicare, to share HEDIS or other appropriate data with State public health departments in order to enhance their public health surveillance function. One way in which HCFA could encourage managed care plans to provide such information is through the QISMC (Quality Improvement System for Managed Care) that Medicare managed care plans and many State Medicaid plans are using. The QISMC uses HEDIS as a major data collection instrument. Consequently, QISMC provides one opportunity through which health plan contracts for both Medicare and Medicaid might place emphasis on incentives to share information with public health agencies.

- ▶ **The Health Resources and Services Administration** could work with organizations it funds, such as community health centers, that participate in managed care networks. The HRSA could help these providers determine how they might enhance data exchange with the State public health departments. As the agency funds grant programs to the States, such as Title V Maternal and Child Health State Block Grants, HRSA could encourage States to provide information on the extent to which

these programs are linking with managed care organizations to obtain data to further the health departments' capacity to conduct disease surveillance activities.

The HRSA also could foster collaborations by encouraging its field units in the Department's Regional Offices to work proactively with the States to initiate collaborative activity with managed care organizations. The Regional Offices, in fact, may be the best positioned of any Department component to initiate these types of activities. The Regional Health Administrators work with State and local officials on multiple health programs funded by the Department. Consequently, they know and are sensitive to the local health care environment and market. Much could be learned from the Region 1 initiative that brings together public health officials and managed care executives from the six New England States to develop collaborative strategies. These officials and plans are working together to develop guidelines for treating asthma, reducing tobacco use, and improving immunization levels, according to locally identified needs.

The HRSA also is sponsoring a series of meetings in conjunction with the American Public Human Services Association, which represents State Medicaid directors. The goal is to bring together State public health providers (such as Maternal and Child Health program directors, Primary Care Association leadership, and Ryan White Act providers) with State Medicaid directors to address issues of mutual concern and to create strong working relationships between Medicaid offices and public health at the State-level. The agency could use these, or similar, meetings as a way to encourage and involve MCOs, as well as local health departments, in collaborative activities.

COMMENTS ON THE DRAFT REPORT

We received written comments on the draft report from the Centers for Disease Control and Prevention (CDC), the Health Care Financing Administration (HCFA), the Health Resources and Services Administration (HRSA), and the Association of State and Territorial Health Officials (ASTHO). In addition, we received verbal comments from staff in the Office of the Assistant Secretary for Planning and Evaluation.

In response to the comments, we have made a number of editorial and technical changes in the text. As suggested by those who commented, we also have included a copy of the mail survey, with frequency distribution of responses, as Appendix B of this report.

Here, we summarize comments from each of the respondents and present our response to the salient points that they raised. The full text of each set of comments is included in Appendix A.

Centers for Disease Control and Prevention

The CDC generally agrees with our report. The agency asks that we clarify wording in the Executive Summary, regarding our characterization of the emphasis it might place upon activities it funds. We have adopted, with minor modification, the CDC's recommended language regarding specific ways of encouraging public health and managed care linkage. We believe that the agency's suggested language provides additional specificity regarding actions that it could take to further the intent of actions we suggested.

The CDC asks us to "amplify the importance of the contract purchasing specifications" that we reference. We recognize these specifications as an important example of interagency cooperation among CDC, HCFA, and HRSA, and we have included CDC's suggested language in the appropriate section of the report.

The CDC also raises concerns that our conclusion is too negative. We based this conclusion on evidence that we found while doing our research — the limited extent and scope of collaborative efforts, and the formidable constraints that confront such collaboration. We continue to believe that constructive movement toward collaboration will not occur naturally; therefore, we encourage the appropriate Federal agencies, including CDC, HCFA, and HRSA, to build upon and enhance the leadership efforts that they have begun to exert.

Health Care Financing Administration

The HCFA concurs with the opportunities for improvement we identified in our report, but the agency raises a number of issues to which we wish to respond.

We are encouraged by the agency's interagency agreement with HRSA and CDC to support data sharing between Medicaid and public health agencies. We view this as an important step. We agree with HCFA that all three agencies should exchange ideas and analysis, as well as data, as a way of furthering collaboration.

The HCFA questions whether it should require Medicaid plans to share HEDIS data with State public health agencies. We believe that HCFA could exert leverage for further collaboration between State Medicaid programs and managed care plans by requiring the sharing of such data. Efforts that encourage Medicaid agencies to coordinate sharing of information and data with public health agencies are an important step in this direction.

The HCFA also asks us to seek the input of State Medicaid directors. In the course of research for this inspection, we carefully considered surveying all Medicaid directors, but opted to focus our survey on public health departments for two reasons. First, we intentionally wished to examine the topic of collaboration from the public health agency perspective, rather than the perspective of contract purchasing arrangements under Medicaid. Second, we had hoped to find collaborations occurring in the private managed care sector (as we found in a few States), as well as Medicaid managed care plans.

Health Resources and Services Administration

The HRSA asks that we replace our suggestion that the agency require States to provide information on linkages with language to encourage the development of voluntary reporting measures, which the agency has developed in negotiations with the States. In response, we modified our language. We encourage the agency to work with States and organizations through grant-funded programs to enhance information exchange on the extent of linkages between States and managed care plans. We believe that having such information available would provide HRSA with a baseline from which the agency could develop further efforts in this area. We believe that having such information is critical for HRSA as it develops the capacity of its Center for Managed Care "to provide technical assistance, training, information dissemination, and evaluation on managed care issues that cross all of HRSA's programs" as noted in its comments.

The HRSA also notes that a major focus of its efforts is on quality of care and service delivery, while obtaining data on disease surveillance is a major focus of the CDC. The reasoning underlying this report and other efforts associated with encouraging collaboration, is that such linkages are vital for effective public health intervention in both population-based health surveillance and service delivery strategies.

Finally, we note HRSA’s statement, “many States are not experienced in delivering population-based health services.” We believe that although public health has increasingly focused on the delivery of personal care services over the past several decades, an important segment of the public health community continues to carry out essential population based functions. It is toward this segment of the public health community that we encourage enhancement and growth through relationships with managed care plans.

Association of State and Territorial Health Officials

The ASTHO raises concerns that our report does not adequately reflect the work being done in many States, particularly the vital public health importance of collaborations that focus on delivery of services, as opposed to population-based activities. We do not in any way wish to diminish the importance of these services. Rather our intent was to focus on population-based activities. We have added language to the report that reflects the vital public health role that delivery of specific public health services plays.

The ASTHO indicates that, while it may be true that State and local public health officials are missing out on opportunities, our report seems to indicate that the problem lies solely with health departments. We do not mean to imply that this situation is solely the fault of public health departments. We do not ascribe blame to either sector. Our text indicates clearly responsibilities and challenges that confront both the public health and the managed care communities. We address, for example, the lack of financial incentives for collaboration among both the public health and managed care sectors, and we noted the increasingly competitive market environment in which managed care plans operate. We certainly agree that it would behoove both the public health and managed care communities to carry out additional research on the costs and benefits of collaboration.

The ASTHO questions why we focus our suggestions for improving collaboration only toward Federal agencies, rather than toward the States, as well. Our jurisdiction is with Federal agencies only, and we do not direct suggestions and recommendations at State and local governments regarding their operations. Instead, in this report we call on our Federal colleagues to exert leadership to encourage collaborations among their partners at the State and local levels. We recognize that moving forward in the endeavors we describe here will take concerted effort and cooperation at all levels.

The ASTHO also urges us to acknowledge current literature that is addressing collaboration such as we describe here. As part of our research for this report, we examined that work, particularly the work cited in the ASTHO comments. This literature is a new and important contribution to the increasing attention being paid to collaboration between managed care and public health. The recent attention being paid to this field reflects, we believe, the types of issues and steps we identify in our analysis.

**FULL TEXT OF COMMENTS
ON DRAFT REPORT**

	PAGE
Centers for Disease Control and Prevention	25
Health Care Financing Administration	27
Health Resources and Services Administration	30
Association of State and Territorial Health Officials	34



Memorandum

Date JUN 11 1999

From Acting Director, Office of Program Support

Subject CDC comments on the Office of Evaluation and Inspection, Draft Report, "Public Health and Managed Care: Opportunities for Collaboration" (OEI-01-98-00170)

To June Gibbs Brown
Inspector General

Thank you for the opportunity to review the draft report, "Public Health and Managed Care: Opportunities for Collaboration." The CDC generally agrees with the contents of the report. The following comments are for your consideration.

1. Page 3, "Opportunities for Improvement": The paragraph beginning with "The CDC should place emphasis in its funding activities . . .": It is not clear to what this recommendation means for individual Divisions. We suggest rewording the recommendation to read as follows:

"The CDC should determine if its funding activities should require or encourage specific activities linking public health with managed care. Where appropriate, the CDC should incorporate into its program announcements and program guidance specific language pertaining to coordination of public health and managed care activities, including data sharing."

2. Page 3, "Opportunities for Improvement," para. 5: Delete the word "model" and insert "sample." The HIV purchasing specifications are sample specifications.

3. Page 7, "Methodology and Scope": The report should explain the time line of its data gathering. This is important because the managed care arena is evolving so rapidly.

4. Page 7, "Methodology and Scope": List each state contacted and the number of telephone interviews completed with state or local public health officials. Also list the number of managed care representatives that were interviewed.

5. Page 17, "Opportunities for Improvements": This section should amplify the importance of the contract purchasing specifications. CDC, HCFA, and HRSA support these specifications/guidelines, which will soon be implemented at the State level. They provide a base structure to establish and negotiate collaboration among public health agencies, purchasers of publicly-funded health services and managed care organizations. Additionally, the specifications address public health issues, quality assurance, data collection and sharing, memoranda of understanding, surveillance, and information systems.

6. Page 17, "Opportunities for Improvement," para. 3, sentences 1 & 2: The word "model" should be replaced by "sample." The HIV purchasing specifications are sample specifications.

7. Page 16, "Conclusion": Although some concerns do exist, the conclusion seems mostly negative and lacks balance. For example, the report could highlight the progress in the contract purchasing specification area or other areas of collaboration.

8. Attach a copy of the mailed survey questionnaire and the structured telephone interview format to the report an appendix.

If you should have questions concerning these comments, please have your staff contact Carolyn Russell, Director, Management Analysis and Services Office, at (404) 639-0440.

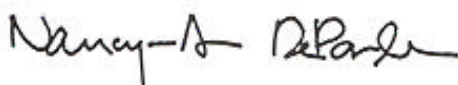


James D. Seligman



DATE: MAY 26 1999

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator 

SUBJECT: Office of Inspector General (OIG) Draft Report: "Public Health and
Managed Care--Opportunities for Collaboration," (OEI-01-98-00170)

We appreciate the recommendations in the above-referenced report regarding opportunities to track disease and health trends and to mount effective interventions through data sharing. To encourage collaboration, the Health Care Financing Administration (HCFA), Health Resources and Services Administration (HRSA), and Centers for Disease Control and Prevention (CDC) have recently signed a formal interagency agreement to support data sharing between state Medicaid and public health agencies. HCFA has also proposed regulations associated with quality measures, that provide added guidance to states and health plans on data collection and data quality issues. However, in order to foster the collaboration needed to achieve maximum benefit from data sharing, we believe an approach is needed that includes not only the exchange of data, but the exchange of ideas and analyses.

We agree with the OIG that Medicaid agencies find benefit in data collected for public health purposes. An obvious example is data in public health records on child immunizations. Yet, these data are often difficult or impossible for Medicaid agencies to obtain. One key issue, mentioned only briefly in the report, is privacy restrictions to data release. HCFA believes that it is critical for personal medical information to be protected. It would be useful if the OIG could further explore what privacy conditions currently exist and how states are trying to balance the benefits of information sharing in this area with the critical need to protect privacy.

Our detailed comments on the report recommendations follow:

OIG Recommendation #1

HCFA should encourage collaboration by developing guidance for states on the kinds of activities that might be included in Medicaid managed care contracts.

HCFA Response

We concur. HCFA encourages states to have their contracting managed care organizations (MCOs) work on public health goals through statewide health care quality improvement projects. HCFA has encouraged this through issuing the Quality Improvement System for Managed Care (QISMC). This was developed through a contract with the National Academy for State Health Policy. QISMC will serve as a basis for HCFA reviewers of managed care plans' performance, based on demonstrable and measurable improvement.

Before this report is finalized, we recommend that OIG seek the input of state Medicaid agencies. One crucial aspect of this draft report is to describe any existing requirements in Medicaid contracts that MCOs collaborate with public health agencies. Because these contracts are generated and administered by the Medicaid agencies, the agencies' input would be crucial. The Medicaid agencies may also be aware of new efforts under development to foster collaboration, and that information could be helpful to the report. We suggest that the draft report be shared as soon as possible with Medicaid agencies to ensure collaborative activities take place.

OIG Recommendation #2

HCFA should provide specific guidance to the states on guidelines that could be communicated to health plans.

HCFA Response

We concur. HCFA encourages states to consult as a valuable resource the model contract language developed by George Washington University as part of a technical assistance project for Medicaid Managed Care programs.

OIG Recommendation #3

HCFA should require managed care plans, both Medicaid and/or Medicare, to share Health Employer Data Information Set (HEDIS) or other appropriate data with state public health departments in order to enhance their surveillance function.

HCFA Response

We concur, but rather than "require" Medicaid managed care plans to share HEDIS or other appropriate data with state public health departments, we encourage state Medicaid agencies, in their contracts with managed care organizations, to coordinate the sharing of information and data with state public health departments. We realize that the data may be difficult to collect in a systematic way, and that there are important concerns regarding privacy and confidentiality that must be addressed.

Nevertheless, we agree with OIG that the state public health departments surveillance function would benefit from such sharing efforts that protect the confidentiality of individuals.

We have already taken steps to promote such activities. As mentioned earlier HCFA developed QISMIC, in order to promote design of a set of standards and tools which would have application for both Medicare and Medicaid populations. This has resulted in the development of QISMIC monitoring tools and a system for measuring compliance and ensuring integration of common philosophies and consistent use of measures. QISMIC will help provide health care plans and states with a vehicle for enhancing efficiency in data reporting. For example, where a HEDIS indicator selected for a Quality Assessment and Performance Improvement project is one routinely required by both HCFA for Medicare and states for Medicaid, health plans are encouraged through QISMIC to collaborate in the collection of such data. In these instances, review of compliance under both Medicare and Medicaid could be a coordinated effort. Further, through QISMIC standard 1.5.2.2, health plans are advised to develop standard formats to ensure that data elements are reported uniformly by all providers, and that reports from multiple sources be comparable and therefore be reliably merged into more comprehensive reports.

The Health Insurance Portability and Accountability Act of 1996 includes data standardization provisions that will apply to health plans and providers. Until these requirements take effect, each organization remains free to specify its own standard requirements. However, because national standardization is forthcoming through QISMIC, HCFA urges health plans to progress rapidly toward commonly accepted data formats which could provide valuable health outcome information to a variety of organizations.

General Comment

The last recommendation for the CDC suggests that "... CDC might require states to document the extent of MCO reporting to communicable disease or cancer registries." We question whether MCOs are the appropriate entities for reporting this information, as health care practitioners, e.g., physicians, are typically the reporting entity. Is this recommendation suggesting that the primary responsibility not rest with health care practitioners, but rather with the insuring entity? Is this approach suggested for all managed care entities, e.g., commercial managed care plans licensed by the state but not serving Medicaid beneficiaries or only MCOs that contract with state Medicaid agencies? Is this proposed as a condition of licensure in a state?



APR. 2 1999

TO: Inspector General, OS
FROM: Deputy Administrator
SUBJECT: Office of Inspector General (OIG) Draft Report
"Public Health and Managed Care: Opportunities for
Collaboration"

Attached, in response to your January 27 memorandum are HRSA's
comments to the subject draft report.

Staff questions may be referred to Michael Herbst on
(301) 443-5256.


Thomas G. Morford

Attachment

Health Resources and Services Administration Comments
On The Office of Inspector General (OIG) Draft Report
"Public Health and Managed Care: Opportunities
for Collaboration" OIG-01-98-00170

General Comments

A review of various documents from the Region VI State Title V Maternal and Child Health (MCH) Programs, feedback from State staff and observations made during joint monitoring visits with the Health Care Financing Administration indicate that the information found in the OIG report is fairly accurate.

The OIG report needs important contextual information added to the methodology and background sections, namely the time period over which data was collected in relation to implementation of Medicaid managed care in the States surveyed. It would also be helpful to add a table or chart outlining State Medicaid managed care programs. The mail survey sent to State Health Officers should also be included as an appendix.

It is important to understand that many States are not experienced in delivering population-based health services. HRSA believes that the States' lack of experience in this area is a major contributing factor to their inability to rapidly advance collaboration with managed care plans to further population-based health activities.

The Title V Maternal and Child Health Block Grant Program is developing performance partnerships with all 59 States and Jurisdictions through which the States and Jurisdictions will voluntarily report on 18 agreed upon core measures and a large number of negotiated State performance measures. The measures are under analysis now and should be released in May. There may be additional State negotiated measures that look at public health and managed care organizations collaborations, but in any case Title V provides fertile ground for encouraging States to develop a performance measure on this topic.

On page 18, the OIG's Opportunities for Improvement Section directed to HRSA, stated that HRSA require States to provide information on these links. In the example cited by the OIG report, the MCH block grant, it would be out of character to require States to provide information not specifically included in the legislation. HRSA has only required States to provide information that is mandated by law. The rest of the information collected needs to be negotiated and agreed upon with the States, as were the 18 core measures and the additional State negotiated

measures. In addition, a major focus of Title V is on quality of care and delivering population based public health services (such as lead based poisoning, immunizations and newborn screening), while obtaining data for disease surveillance activities is a major focus of the Center of Disease Control and Prevention (CDC).

TECHNICAL COMMENTS

Page 3, paragraph 2, last line:
Delete "and" before lead paint poisoning then add after poisoning ",and HIV/AIDS." to the last sentence.

Page 3, paragraph 6, 2nd line:
Add "and Ryan White CARE Act-funded providers" after "centers."

Page 7, paragraph 2:
After "HRSA" add "has a strong managed care focus in all of its Bureaus. The Bureaus support a widely established range of activities from helping health centers assess proposed managed care contracts and managed care networks to assuring the availability of quality care providers, guidelines, and resources for HIV/AIDS patients and children with special health care needs. In addition to Bureau-level technical assistance activities, HRSA established the Center for Managed Care in 1996 to provide technical assistance, training, information dissemination and evaluation on managed care issues that cross all of HRSA's programs."

Page 18 last paragraph:
Delete the paragraph and replace it with "As HRSA funds State Title V Maternal and Child Health State Block Grants, HRSA's Maternal and Child Health Bureau could negotiate with States to develop performance partnership measures on the extent to which State and local health departments are collaborating with managed care organizations to carry out public health functions. HRSA and CDC could also work together to help State health departments work with organized delivery systems to design information systems that enhance their capacity and ability to share data related to disease surveillance and quality of care. Additionally, HRSA could provide technical assistance on data collection and routine information exchange with health departments."

-3-

Page 19, last paragraph, 2nd line:
Add an "s" to director.

Page 19, last paragraph, 4th line:
Add "CARE" after "Ryan White" and before "Act."



Ms. June Gibbs Brown
Inspector General
Department of Health and Human Services
Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

March 10, 1997

Dear Ms. Brown:

OEI-01-98-00170

Thank you very much for the opportunity to review and comment on the draft Office of Inspector General report entitled *"Public Health and Managed Care: Opportunities for Collaboration."* We appreciate the Department's interest in assessing how state and local public health agencies are taking advantage of opportunities for collaboration with managed care plans to further population-based health activities, and offer the following comments on the draft:

- While we understand that the focus of the report is on collaborations to further population-based activities, ASTHO is concerned that the conclusion that "collaborations have barely begun" does not adequately reflect the important work that is being done in many states. As the study notes, 16 states report requiring managed care organizations to collaborate with public health departments and another 27 states report voluntary activities. As indicated, many of these collaborations focus on the "delivery of services," however the report does not acknowledge that many of these services include STD, HIV, and TB testing and treatment, family planning, and both childhood and adult immunizations, which have a clear impact on the public's health. We recommend that the report acknowledge the vital public health importance of such collaborations, even if they are for personal health services. Additionally, a 1997 study conducted by our affiliate Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPE) reported that 45 (or 90%) of State Health Department Health Promotion Divisions were involved in at least one activity with managed care organizations addressing health promotion or public health education.¹
- ASTHO is further concerned that in the cover letter accompanying the draft, the OIG declares that "State and local public health officials are missing out on good opportunities to improve their ability to track and trace diseases in communities, control exposures that can threaten the population, and develop programs to respond to changes in the health status and needs of communities." While this may be true, it

¹ Schauffler, Helen H. et al, "Health Promotion and Managed Care: An Assessment of Collaboration by State Directors of Health Promotion." Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPE), April 1997. Pg. 4.

seems to indicate the problem lies solely with health departments and does not present a balanced view regarding the responsibilities of managed care organizations. Additionally, the report's discussion of challenges to collaboration does not explicitly acknowledge the lack of incentives for managed care to collaborate with public health. There is also currently a lack of convincing evidence that involvement in public health activities can positively impact an MCO's "bottom line." The OIG may want to consider recommending that more research into this area be conducted.

- The report draws the conclusion that the opportunities for collaboration may be "fading." While this may also be true, we are concerned that this point could be misinterpreted as being a result of inaction on the part of states rather than due to the increasingly competitive managed care market and its evolution toward decentralized network models. We would appreciate clarification of this point, again in the interest of providing a balanced view of the mutual responsibilities of both public health and managed care leadership.
- ASTHO is perplexed that the draft report focuses on collaborations at the state and local health department level, but only directs suggestions for improving collaborations to the federal level (i.e. CDC, HCFA, and HRSA.) While ASTHO values our relationships with these key partners, we are concerned that further mandates from the federal level may not reflect unique state and local conditions and run counter to the spirit and definition of "collaboration."
- Finally, regarding the discussion of challenges to collaboration, particularly the "isolation between the medical and public health sectors," we suggest that the report acknowledge the leadership to address this issue displayed by the American Public Health Association and American Medical Association's Medicine & Public Health Initiative and the work of the New York Academy of Medicine² to promote and document collaborations between the public health and medical sectors, including collaborations with MCOs.

We appreciate your consideration of these comments, and again thank you for the opportunity to review the draft report. If you have any questions, please do not hesitate to contact us or Brent Ewig from the ASTHO staff at 202-371-9090. We look forward to the final report.

Sincerely,

Ed Thompson, MD / B.H.S.
Ed Thompson, MD, MPH
Mississippi State Health Officer
President, ASTHO

Fredia Wadley, MD / B.M.E.
Fredia Wadley, MD, MSHPA
Tennessee State Health Officer
Chair, ASTHO Access Policy Committee

² Lasker, Roz et al, "Medicine and Public Health: The Power of Collaboration" and "Pocket Guide to Cases of Medicine and Public Health Collaboration." New York Academy of Medicine, New York, NY, 1997 and 1998.

FREQUENCY DISTRIBUTION OF MAIL SURVEY



**U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF EVALUATION & INSPECTIONS**

Survey of State Health Officers

This survey is part of a study being conducted by the Office of Inspector General, U.S. Department of Health and Human Services. The purpose of the study is to assess the extent to which State and Local public health departments are collaborating with managed care plans to further public health activities.

This survey seeks basic information about collaborations between health departments and managed care plans. For the purposes of this survey, our concern is with managed care plans, such as health maintenance organizations and similar entities, that are licensed or regulated by your State.

Information that you provide in this survey will help us to develop a comprehensive national picture of collaborations between public health departments and managed care plans. We are also interested to learn details about any innovative activities taking place in your State.

Please identify your State and the name of the person completing the survey in case we need additional information or clarification:

State: Frequency Distribution of 47 Survey Responses

Name of person completing survey: _____

Title and Department: _____

Phone number and email: _____

Please return your completed survey by Friday, June 19.

Return the survey either by Fax to (617) 565-3751,

or in the enclosed business reply envelope to:

OIG-OEI Room 2475, JFK Federal Building, Boston, MA 02203

If you have any questions about the survey, please contact:

Russell Hereford (617-565-1054, email: rherefor@os.dhhs.gov)

Nikki Pinson (617-565-1056, email npinson@os.dhhs.gov)

MECHANISMS FOR COLLABORATION: *This section seeks information about any formal mechanisms that require collaborations between managed care plans and public health departments in your State.*

1. Does your State require managed care plans to formally identify how they will collaborate with State or Local health departments to further public health activities?

YES If “Yes,” please check any of the following formal mechanisms that apply. Please send us a copy of the relevant regulations or statutes governing these provisions; please provide references to published materials, web sites, and any citations that we might look up ourselves. **N=16**

1a. Collaboration required by State law. **N=9**

1b. Collaboration required by State Health Department regulations. **N=6**

1c. Collaboration required by other State agency regulations (*please specify agency*): **N=2**

d. Other: Collaboration required by other formal mechanism (*please specify mechanism*): **N=7**

NO If managed care plans are not required to identify how they will collaborate with public health departments in your State, *please skip to the last page of the survey (page 9)*. **N=31**

If you answered “Yes,” please continue to next page

TYPES OF COLLABORATIVE ACTIVITIES: *This section seeks information about the types of public health functions that the collaborations are pursuing. Please include any functions that are not listed. We are also interested in examples of particularly significant collaborations in your State.*

2. Please estimate the level of activity that the collaborations devote to the following public health functions.				
Function	No activity	Limited activity	Moderate activity	Extensive activity
Surveillance functions				
2a. Environmental exposure data	2	2	2	0
2b. Disease incidence data	2	10	2	2
2c. Reportable disease data	4	6	2	4
2d. Laboratory data	8	5	1	2
2e. Population-based data registries	7	4	2	3
2f. Other: _____	13	0	1	1
Population-focused functions				
2g. Planning and policy development	6	2	7	1
2h. Health education campaigns	2	8	6	0
2i. Provider education	4	5	6	1
2j. Environmental interventions	9	7	0	0
2k. Other: _____	15	0	0	0
Functions focused on individuals				
2l. Delivery of services	2	2	9	3
2m. Operation of school-based programs	5	7	3	1
2n. Case management/ Enabling services	3	4	7	2
2o. Other: _____	14	0	1	0

3. Please provide examples of particularly significant collaborative activities; please include the names, affiliation, and phone numbers/e-mail of people we might contact for more information.

COLLABORATIVE PLANNING: *This section seeks information about the collaborative planning process. Please provide information about the groups involved in planning the collaborations and the information sources used to identify areas on which to collaborate.*

4. To what extent do the following groups play roles in planning the collaborations?				
Group	No role	Limited role	Moderate role	Extensive role
4a. State Health Department	2	1	4	9
4b. Medicaid agency	1	2	4	9
4c. Local health agencies	3	6	3	4
4d. State Legislature	4	9	1	2
4e. Managed care plans	1	1	8	6
4f. Practitioners affiliated with managed care plans	4	9	1	2
4g. Hospitals affiliated with managed care plans	4	7	4	1
4h. Purchasers/ Business	8	6	1	1
4i. Community organizations	5	6	3	2
4j. Voluntary health organizations	7	5	2	2
4k. Other groups:	12	2	1	1

5. What role do the following sources play in identifying health issues for collaboration between managed care plans and public health agencies?				
Sources	No role	Limited role	Moderate role	Extensive role
Published sources				
5a. <i>Healthy People 2000</i> goals	1	6	8	1
5b. State public health goals	0	4	7	5
Population-based data				
5c. State Health Department data	0	3	7	6
5d. Medicaid data	2	2	5	7
5e. Local health agency data	5	6	2	3
Health plan data				
5f. HEDIS indicators	3	2	6	5
5g. Plan encounter data	3	5	3	5
5h. Other sources:	13	0	1	1

IMPLEMENTATION: *This section seeks information about the implementation of the collaborations. We are interested in 1.) if the implementation is required or voluntary and 2.) which groups are involved in implementing the collaborations.*

6. Are managed care plans required to implement collaborative activities that have been identified or planned?

REQUIRED. Managed care plans are required to implement collaborative activities that have been planned or identified. N =9

NOT REQUIRED. Implementation of collaborations is voluntary. N =9

OTHER. (Please explain): N =1

7. To what extent do the following groups play roles in implementing the collaborations?				
Group	No role	Limited role	Moderate role	Extensive role
7a. State Health Department	1	0	9	6
7b. Medicaid agency	2	4	2	8
7c. Local health agencies	3	4	5	4
7d. State Legislature	9	5	1	1
7e. Managed care plans	0	3	7	6
7f. Practitioners affiliated with managed care plans	3	8	2	3
7g. Hospitals affiliated with managed care plans	4	9	2	1
7h. Purchasers/ Business	9	5	1	1
7i. Community organizations	4	7	3	2
7j. Voluntary health organizations	9	4	1	2
7k. Other Groups:	13	0	2	1

OUTCOMES ASSESSMENT: *This section seeks information about measuring the outcomes of the collaborations.*

8. Does your State assess the outcomes of the collaborations?

N =9 **YES**, our State assesses the outcomes of collaborations.

N =7 **NO**, our State does not assess the outcomes of collaborations.
(Please skip to Question 10).

8a. How does your State assess the outcomes of the collaborations? *(Please send us copies of any formal outcomes measures used or reports prepared.)*

9. To what extent do the following groups play roles in assessing the outcomes of the collaborations?				
Group	No role	Limited role	Moderate role	Extensive role
9a. State Health Department	7	3	1	5
9b. Medicaid agency	8	2	1	5
9c. Local health agencies	9	5	1	1
9d. State Legislature	11	3	0	2
9e. Managed care plans	8	2	1	5
9f. Practitioners affiliated with managed care plans	8	4	1	3
9g. Hospitals affiliated with managed care plans	9	4	1	2
9h. Purchasers/ Business	12	3	0	1
9i. Community organizations	11	3	0	2
9j. Voluntary health organizations	11	2	1	2
9k. Other Groups:	15	0	0	1

OBSTACLES TO COLLABORATION: *This section seeks information about obstacles that make collaborations in your State difficult. Please describe any obstacles that are not listed.*

10. In your opinion, to what extent do the following obstacles hinder successful collaboration between public health departments and managed care plans?				
	No obstacle	Minor obstacle	Moderate obstacle	Major obstacle
Within the public health community:				
10a. Lack of knowledge about managed care.	4	3	5	4
10b. Lack of clearly defined public health goals.	7	4	4	1
10c. Fragmentation of public health authority and responsibility across multiple State agencies.	4	8	3	1
10d. General distrust of managed care plans.	3	2	7	4
10e. Concern about losing service delivery role to managed care plans.	3	1	8	4
Within the managed care community:				
10f. Lack of awareness of public health agencies and activities in the community.	1	2	6	7
10g. Public health goals not integrated into core business strategies of managed care plans.	0	1	5	10
10h. Medical providers do not view collaboration with public health departments as a priority.	0	5	5	6
10i. Purchasers do not view collaboration with public health departments as a priority.	1	3	4	8
Data concerns:				
10j. Technical difficulties in matching data systems.	2	3	5	6
10k. Regulatory barriers to accessing Medicaid data.	5	6	4	1
10l. Privacy/ confidentiality concerns.	3	5	7	1
10m. Competition among health plans/ concern about releasing proprietary information.	2	3	8	3
10n. Fear that data will be used for regulatory purposes.	3	3	7	3

11. Please tell us about any other major obstacles to collaboration that you have encountered (please use back of page if needed)

ACCOMPLISHMENTS: *This section seeks information about what the collaborations have achieved and what you hope to see in their future.*

12. Accomplishments: What have been the most significant accomplishments to date of the collaborations between managed care plans and public health departments?

13. Do you expect your State to continue the collaborative activity?

YES (*please answer question 14*). **N=16**

NO (*you have completed the survey, please see instructions below*). **N=0**

14. What opportunities do you hope to realize through collaborations in the future?

Thank you for completing the survey.

Please return your completed survey by Friday, June 19.

Return the survey either by Fax to 617- 565-3751, or in the enclosed business reply envelope to:
OIG-OEI, Room 2475, JFK Federal Building, Boston, MA 02203

If you have any questions about the survey, please contact:
Russell Hereford (617-565-1054, email: rherefor@os.dhhs.gov)
Nikki Pinson (617-565-1056, email: npinson@os.dhhs.gov)

Please answer the following questions if your State is not involved in collaborative activities:

	Unlikely	Possible	Likely	Very likely
15. How likely is it that your State will develop collaborations between public health agencies and managed care plans in the next two years?	4	11	7	9

16. Are there significant voluntary collaborations between managed care plans and your State’s public health community that are seeking to further public health activities at the State and Local levels?

YES, there are voluntary collaborations between managed care plans and public health departments in our State. (*please answer questions 17 and 18*). N =27

NO, there are no voluntary collaborations between managed care plans and public health departments in our State. (*please skip to question 18*). N =4

17. Please estimate the number of voluntary collaborations that are occurring in your State at the State and Local levels:

17a. State-level (please estimate number): 0-8

17b. Local-level (please estimate number): 0-96

18. To what extent do the following prevent your State from establishing collaborations between public health and managed care?				
Obstacles preventing collaboration	No obstacle	Minor obstacle	Moderate obstacle	Major obstacle
18a. Lack of knowledge about managed care.	9	13	9	0
18b. General distrust of managed care plans.	10	8	11	2
18c. Concerns about public health departments losing their service delivery role to managed care plans.	10	5	12	4
18d. Managed care’s lack of awareness of public health agency activities.	4	4	12	11
18e. Managed care plans are not a significant service delivery system in your State.	13	4	8	6
18f. Other obstacles:	0	0	3	3

Thank you for completing the survey. Please return by Friday, June 19 following instructions on cover page.

ENDNOTES

1. Institute of Medicine, *Healthy Communities: New Partnerships for the Future of Public Health*, (Washington, DC: National Academy Press, 1996), 15.
2. U.S. Department of Health and Human Services, *Strategic Plan*, September 30, 1997, p. 5-1.
3. U.S. Department of Health and Human Services, Health Resources and Services Administration, *Meeting the Challenge: HRSA and Managed Care*. November, 1997, p. 1.
4. We recognize that the survey and data collection for this report are one year old, and it is plausible that changes may have taken place over time. However, considering the continued competition and changes in the managed care market place, and the formidable constraints our findings identify, it seems unlikely that significant developments have occurred.