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Women and Managed Care in California: An Examination of Selected Services

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UCLA Center for Health Policy Research

and

Pacific Institute for Women's Health

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Executive Summary

Background and Methodology

Managed care is becoming the dominant system of health care coverage and delivery throughout the United States and particularly in California, for both private and public sector health care. This report examines the availability and structure of health care for women in managed care settings, focusing on selected areas.

The report presents findings from a written questionnaire survey of commerical managed care plans in California and in Medi-Cal managed care systems (local initiatives and county organized health systems). Of the 33 commercial managed care plans surveyed, 27 responded. Of 13 local initiatives or county organized health systems, 12 responded to the questionnaire. Overall, the response rate was 84%. Follow-up interviews with 25 health care providers within the responding plans provided experiences that augment the written responses and help to identify themes in practice settings.

This report provides a description of how selected services for women within managed care in California are organized and what services for women are emphasized. In both commercial and Medi-Cal managed care plans, health promotion, disease prevention, and well women services were examined. Examination of mental health and substance abuse services was primarily directed toward the commercial plans, because Medi-Cal managed care typically uses a different system of care to cover those services.

Conclusions

The findings from this study provide a starting point for understanding how managed care has tried to address and organize women's health care services.

Preventive Health Services Offered by Most Plans

Women's preventive health services are offered by most managed care plans throughout California. In addition to clinical preventive screenings, health promotion activities, smoking cessation and nutrition counseling were offered by many plans. Weight reduction, stress reduction, mental health promotion, and substance abuse prevention were not widely offered. Managed care plans need to conduct more outreach, improve access, and give greater support to these important health promotion activities.

Carve-Outs Can Increase Fragmentation

Mental health and substance abuse services were often carved out of commercial managed care plans, making them external to the managed care plan and the enrollee's usual source of care. Primary care providers reported concerns with referring patients to providers they were not familiar with, as well as a lack of mental health and substance abuse providers to whom to refer patients. In addition, primary care providers often do not have access to information about treatment their patients may be receiving, except from the patient herself. Furthermore, high co-payments may deter those seeking care. Managed care plans need to explore more effective ways to increase access and preserve continuity of mental health and substance abuse care while protecting patient confidentiality. Recently passed legislation will address some of the issues related to parity by requiring diagnosis and treatment of mental illness under the same rates, terms, and conditions as other medical conditions.

Promotion Services Need to Be Broadened and Expanded

Mental-health related services such as domestic violence prevention, treatment for eating disorders, stress reduction, and alcohol and substance abuse are priorities to many women, but are not systematically assessed in the managed care setting. Domestic violence has only recently gained attention from a few plans. The organizational responsibility and structure of women's health in managed care can potentially address the current gaps in coverage by providing a vision that encompasses the multiple health needs among women throughout the life course.

All Plans Need Stronger Links with Public Health Agencies

Partnerships between managed care plans and public health agencies could help to strengthen efforts to improve the population's health. Commercial managed care plans could benefit, as Medi-Cal plans already do, from closer linkages with public health agencies. Many public health agencies have public education and outreach programs that would be beneficial to all women. The experience of the public health agencies and their understanding of population-based health make collaborative efforts important.

The Perspective on Women's Health Is Limited

Managed care has not yet fostered a cohesive and comprehensive approach to delivering women's health care. Fragmentation of services continues to exist throughout the system. For example, the well-woman benefit offered by many plans sounds like a comprehensive approach to women's health care, but primarily focuses on reproductive health care.

Summary

These findings show important accomplishments and significant deficits. Managed care plans cover and largely promote clinical preventive health services, particularly breast and cervical cancer screening, and smoking and nutrition counseling. But managed care plans need to consider stronger mandates for more comprehensive programs in women's health that will cover a broader range of services throughout the life cycle. Furthermore, coverage for mental health services needs to be extended, co-payments reduced, and a more integrated system of assessment and referral with medical care providers developed. More outcome measures are needed in order to assess the impact of managed care on women's health, and more research is needed to better understand how to organize women's health services to optimize health outcomes in managed care settings.

Introduction

Women and Managed Care in California: An Examination of Selected Services provides the first statewide view of women's health in managed care, by examining the delivery of selected services. This topic takes on even greater importance as managed care becomes the predominant system of health care coverage and delivery in the state. The transformation to a managed care payment and delivery system is one of the major changes occurring in the health care system in the United States. An estimated 58.2 million Americans are enrolled in managed care plans, with a sizable proportion from California.[1] Medi-Cal (California's Medicaid program) is shifting its recipients to managed care from fee-for-service arrangements. Approximately 2 million Medi-Cal beneficiaries (40% of the total) were enrolled in managed care as of May 1998.[2]

Women are the dominant users of the health care system. As gatekeepers for their families and as primary users of health care services for themselves, women tend to utilize the health care system more frequently than men. Poor women also make up the majority of Medi-Cal recipients and thus are the most likely to be affected by the shift to managed care in the public sector. Therefore, women's health, its financing and its delivery are of particular importance in the current landscape of managed care.

Health care for women has historically been characterized as fragmented and not sensitive to gender issues, criticisms that predate the predominance of managed care. Managed care affords an opportunity to address these issues and improve the current gaps in women's health care. However, managed care often encourages less use of services, particularly specialty ones, and this works against better care delivery.

A 1997 report, *Low-Income Women and Managed Care in California,* presented the findings from a series of focus groups that examined the experiences of publicly and privately insured women seeking medical care through the managed care system.[3] The findings from these focus groups helped to formulate the questions for this study. The 1997 report found that lack, or inadequate coverage, of services, along with co-payment obligations, delayed or prevented initiation of care. The findings also showed that women wanted a more preventive approach to care that included regular health promotion assessments and reminders for preventive health screenings. These women wanted more attention paid to health behaviors such as smoking, diet, exercise, stress, and alcohol and substance abuse. These issues formed the framework for the survey of health plans in California presented in this report.

Goals of the Report

This report examined the provision of health care for women in managed care in California by looking at the following services: health promotion, disease prevention, mental health, and substance abuse. Thus, the report examined selected services only, not the full range that women require. Looking at these selected services provided a contrast: Health promotion and disease prevention have historically been covered in managed care plans, especially the older-style models with integrated delivery systems. But mental health and substance abuse programs have typically been separated from physical health coverage, and have not achieved the same parity.

The report examined several aspects of these services within managed care plans. It looked at which services were covered, co-payment arrangements, contractual arrangements for service provision, the use of clinical guidelines and assessment protocols, incentives to influence provider practice, reporting of process and outcome indicators, collaboration with county and state agencies, and overall women's health within managed care plans.

This report presents findings from a questionnaire conducted with commercial managed care plans in California and Medi-Cal managed care systems (local initiatives and county organized health systems). Interviews with providers supplement the survey data received from the plans and focus on their experiences in offering services to women.

Methods

Survey of Managed Care Plans

Commercial managed care plans, Medi-Cal local initiatives (LIs), and county organized health systems (COHSs) were surveyed for this report. The commercial managed care plans that constituted the population of surveyed plans were full-service HMOs listed in the June 1997 Knox Keene listing published by the Department of Corporations (n=33). The managed care environment is constantly changing in California, so the composition of plans in California has changed somewhat since the study was conducted. The Medi-Cal plans that participated in the survey were the local initiatives and county organized health systems active as of the date of survey initiation (n=13).

The primary data collection occurred from September 1997 through the middle of 1998. Written questionnaires were sent to the medical directors of each plan on our survey list. Although medical directors were the primary respondents, in a few plans, the medical director referred us to another staff person to complete the questionnaire.

Of the 33 commercial plans surveyed, 27 responded. Of the 13 local initiatives and county organized health systems, 12 responded. Overall, the response rate was 84%. The smaller commercial plans were the least likely to respond. Limited resources or lack of data were often cited as reasons for non-participation. Managed care plans have been heavily surveyed in California recently, making data collection by individual researchers and policymakers increasingly difficult, and increasing plans' respondent and financial burdens. Furthermore, there was no centralized, computerized managed care data information system in California from which interested parties could obtain information.

Based on the survey response rate and, for non-surveyed plans, comparative data from the California Association of Health Maintenance Organizations, the plans that participated in this survey covered approximately 98% of California's 1997 managed care enrollees. (However, the unit of analysis in this report is plans, not enrollees.)

Interviews with Providers

In addition to the survey of managed care plans, structured interviews were conducted with providers in the sampled commercial managed care plans or the local initiatives. This qualitative portion of the study was used to enhance and elaborate on plan findings. The provider sample selection was done in stages. First, a sample of plans was selected from the list of commercial plans surveyed, in order to obtain a range based on type and size. For each plan selected, provider directories were obtained. From these directories, a primary care provider was selected based on a table of random digits; this process continued until 1–2 providers from each plan were interviewed. Seventeen primary care providers were interviewed. In addition, eight interviews were conducted, based on referrals from the primary care providers, with non-physician health care providers in the areas of health promotion, mental health, and substance abuse.

The information from the provider interviews augmented plan findings. It was not meant to be representative of all providers, but rather illustrative of the interviewed providers' experiences, which could help to identify themes in practice settings.

Data Analysis

The data from the managed care plan questionnaires were entered into a computer database and frequencies were calculated using the Statistical Analysis System. The information from the provider interviews was analyzed using content analysis to ascertain common themes.

Commercial Managed Care Plans

Services and Programs Covered

There are several facets of health plan benefit packages that are important to women. The range of services provided by a health care plan is an important component of the benefit package. "The benefit package contains the rules for obtaining care," as well as a road map for access and delivery of care, plus services covered.[4] Although a covered benefit does not ensure access to those services under all circumstances, it establishes that the service is included in the package available to members of that health plan. Whether or not a specific service is actually offered or paid for by the health plan may be determined by the health plan's or a physician's determination of the medical necessity of a service for an individual member.

Table 1 shows, for the selected benefits addressed in this report, information on the percent of commercial plans reporting that they cover the service and the percent reporting they do not. (The combined percent does not always equal 100 because some plans did not respond to this question.)

Table 1: Coverage of Selected Benefits, Best-Selling Product, Commercial Managed Care Plans, California, 1997

Selected Benefit	Percent of Plans That Cover	Percent of Plans That Do Not Cover	Number of Plans That Reported Information
Screening			
Pap smear	100%	--	27
Screening mammography	100%	--	27
Routine physical examination	100%	--	27
Health promotion programs	93%	4%	26
Health education programs	89%	4%	25
Mental health services			
Outpatient	82%	4%	23
Inpatient	70%	15%	23
Substance abuse services			
Outpatient	69%	19%	23
Inpatient	63%	22%	23
Total number of plans			**27**

Coverage for Preventive Screenings, Health Promotion, and Health Education

In general, HMOs are known for providing better coverage of clinical preventive services and other prevention services than fee-for-service arrangements. All commercial HMOs in the survey reported that they offered the following preventive services as part of their best-selling health plan: Pap smear, screening mammography, and routine physical examination (Table 1). Furthermore, almost all plans (more than 90%) reported that they covered some form of health promotion and health education services. These screening and promotion programs are an important aspect of HMO plan offerings and an important factor distinguishing HMOs from PPOs and indemnity plans, which typically offer fewer preventive services.[5]

Of plans that stated the numerical interval during which screenings were covered, 12 out of 17 plans reported that they covered the Pap test annually, four reported an interval from 1–3 years, and one reported a two-year interval. For mammography screening for women ages 50-64, 13 out of 17 reporting plans indicated that they covered annual screenings, three reported a 1–2 year interval and one reported a 2-year interval. Mammography screening coverage intervals for women ages 40–49 were slightly wider. Of 14 plans reporting, one offered no coverage, five covered every year, four every two years, two covered every 1–2 years, one every 1–3 years, and one on a 5-year interval.

In addition to those plans reporting specific intervals for Pap tests and mammography, four plans that did not report any screening interval stated that those terms were determined by the physician or the medical group.

Although commercial managed care plans are covering these screenings, many women are inadequately screened. A study reporting on already calculated performance measures of 13 commercial HMOs in California found considerable variation across plans regarding receipt of mammograms and Pap test among members. On average, 67% of women enrolled in the HMOs had a Pap test within the past three years and 69% of women 50 and over had a mammogram in the past two years.[6] Costs can deter individuals from obtaining needed clinical preventive services. In a national study, nearly one-third of insured women reported that costs were the main reason they had not received a clinical preventive service.[8] The UC Berkeley Survey of California Health Plans found that 76% of plans required co-payments for a Pap smear and physical examination, while 52% required them for screening mammography.[7]

Provider Perspectives on Prevention and Health Promotion Services

In addition to the survey of plans, interviews were conducted with selected health care providers in those plans to augment the data. This qualitative portion of the study was meant to supplement survey information and highlight common themes among the providers, but the results are not meant to be generalized to all providers. Interviews conducted with providers practicing in the plans surveyed indicated that the majority were, for the most part, satisfied with the preventive and health promotion services that their female patients were receiving. One problem the providers noted was the cost to the patient for using preventive services, and the concern that although services may have been offered, they were not always covered completely. (Other studies have shown that the costs of health care are a major concern for women.)

In addition to the problems with service costs, other limitations in the provision of preventive services that were commonly mentioned by the interviewed providers were lack of transportation to the office, lack of child care, and language differences.

Some providers also noted that patient reluctance to seriously adopt healthier behaviors limited the provision of these services.

Coverage of Mental Health and Substance Abuse Services

Compared with clinical preventive screenings and health promotion, there was more variability across plans in the coverage of mental health and substance abuse services; overall, these latter two services were less likely to be covered by plans (Table 1). (The percentages in Table 1 represent plans reporting. Thus, the columns do not always add to 100%.) In general, it was more difficult to obtain information on mental health and substance abuse services. Of the plans that did not report about specific services, two reported that their mental health/substance abuse services were carved out or separate, and therefore they did not have information. But several plans with carved out mental health and substance abuse services were able to report information about them.

Structure of Mental Health/Substance Abuse Services

Many of the plans that reported information stated that their mental health and substance abuse services were carved out from general health care, providing a capitated rate to a separate organization that delivered all or a portion of mental health benefits to enrollees.[9] Nearly half the plans reported that their mental health and substance abuse services were fully carved out; that is, all services were provided through a separate entity for a capitated rate (Table 2). Seven percent reported a partial carve-out; that is, only selected services were provided through a separate capitated provider. Four percent reported that only selected management services were carved out. Nineteen percent reported full integration of mental health and substance abuse services within the plan; and 4 percent reported other arrangements. Four plans did not report information.

Table 2: Most Common Approach to Structuring Mental Health and Substance Abuse Services, Commercial Managed Care Plans, California, 1997

Structure of Mental Health and Substance Abuse Services	Percent and Number of Plans That Use This Approach	
Full carve-out	48%	13
Partial carve-out	7%	2
Management carve-out	4%	1
Fully integrated plan	19%	5
Other approach	4%	1
Do not offer	4%	1
No response to question	14%	4
Total percent and number	**100%**	**27**

During the past decade, behavioral health carve-outs, which typically include combined mental health and substance abuse services, have become increasingly used by commercial health plans or by employers, who directly contract to the mental health service. There is currently no body of data on the differences in the quality of care between integrated and carved-out services. The concern among critics is that carved-out services further separate mental health and substance abuse treatment from other health care services. If true, this can reinforce the already stigmatized place that these services occupy in the health care delivery system. Furthermore, it will fragment receipt of these services and prevent their integration into the treatment plan. On the other hand, the concentrated focus on behavioral health services and the opportunity for management of these services are arguments that are used in support of this approach.

Co-payments for Mental Health and Substance Abuse Services

Of the plans that responded and reported that they provided outpatient mental health services (n=22), 18 reported that they required co-payments for mental health services, one reported no co-payments, and three did not respond. Of those plans that reported outpatient coverage for substance abuse (n=18), 14 plans reported they required co-payments, one reported no co-payments, and three did not respond.

Co-payments were slightly less common for inpatient mental health and inpatient substance abuse services. Of the plans that reported coverage for inpatient mental health services (n=18), 11 reported the use of co-payments, five reported no co-payments, and two did not respond. For inpatient substance abuse (n=17), 12 reported co-payments, two reported no co-payments, and three did not respond.

In addition to co-payments, coverage limits (expressed as either number of visits or days) also pose concerns for consumers in managed care plans, and could be particularly problematic for services such as mental health and substance abuse. A separate study of managed care plans in California found that there was variation in coverage limits among the plans' best selling HMO products. For outpatient mental health services, the median number of visits covered was 20, with a range of 10-25. For inpatient services, the median number of days covered was 20, with a range of 5-30. For outpatient substance abuse, the median number of visits was 20, with a range of 5-25 visits; for inpatient substance abuse the range was 3-30 days, with a median of 10.[10]

There are few population-based surveys available detailing the ability of California women to access mental health services. The 1997 Women's Health Survey provided us with much-needed information about the demand for these services and access to them. Twenty-one percent of women wanted assistance from a mental health professional in a one-year period and, of these women, 53% received that care.[11] Black and Native American women were the most likely to want care, but the least likely to receive it. Although these data were not broken down by insurance status, the large proportion of women who wanted mental health assistance and the high proportion who did not receive it speak to the need for greater attention to this often-neglected health care service.

Referral to Mental Health and Substance Abuse Services

When asked how members accessed mental health and substance abuse services, physician referral, rather than member self-referral, was more commonly stated as a method. Plan respondents had the option to answer affirmatively to both methods. Of 17 plans responding, 12 stated that patients could self refer for mental health services and five responded they could not. More common was primary care physician referral; 18 of 20 reported this referral approach. For substance abuse services, nine plans (out of 15 reporting) stated that members could self refer and six plans said they could not. Physician referral was also more typical for substance abuse services: 18 out of 18 reported this approach.

Provider Perspectives on Mental Health Coverage

The providers interviewed for this study were generally satisfied with the prevention and health promotion services provided. There was more dissatisfaction, however, among interviewed providers with the mental health and substance abuse services that their patients received. Most of this dissatisfaction was due to the lack of adequate referral options to mental health providers. Appropriate providers were said to be either in short supply in the community, not accepting more referrals, or not approved by the managed care plan.

Additionally, some providers were concerned about the quality of service that their patients were receiving, either because they were required to initially treat the patient themselves and did not feel qualified, they could not refer to the specialist that they felt was best suited for a particular patient, or they did not know the provider to whom they were making the referral. Some providers also stated that they found the length of each session, or the number of sessions authorized by the plans for mental health and substance abuse services, to be inadequate. Although a plan benefit may have provided a maximum number of sessions per year (for example, 20 per year), approval from the plan for that number may actually have been difficult to obtain.

Provider Perspectives on Substance Abuse Services

The interviewed providers reported much less contact with female patients who needed substance abuse treatment than with those who required mental health care. County facilities were used, as were private options, when referrals for treatment were indicated. The main concern expressed by providers regarding substance abuse care was the duration of treatment. Also mentioned was the unrealistic expectation that recovery will occur within a short time period — an expectation that is typically not applied to the management of chronic physical health problems.

Coverage of Specific Health Promotion Programs

Table 3 shows the specific health promotion programs that managed care plans offer to most members. The most commonly offered are smoking cessation (82%) and nutrition counseling (78%).

Table 3: Coverage of Selected Health Promotion Programs, Best-Selling Product, Commercial Managed Care Plans, California, 1997

Health Promotion Programs	Percent of Plans That Offer	Percent of Plans That Do Not Offer	Number of Plans That Reported Information
Smoking cessation	82%	11%	25
Nutrition counseling	78%	19%	26
Weight loss program	52%	41%	25
Stress reduction classes	56%	33%	24
Mental health promotion	52%	37%	24
Substance abuse prevention	52%	37%	24
Total number of plans			**27**

Less likely to be offered were weight-loss programs, mental health promotion, stress reduction classes, and substance abuse prevention. In each case, approximately one-third or more of plans reported that these services were not offered.

Although the majority of commercial managed care plans offered some type of health promotion program, population-based data showed that the participation rates among insured adults in California were low. One study showed that only 6% of adults with private coverage reported participating in a health plan-offered health promotion program during 1997.[12] Rates rise to 18% when any sponsored health promotion program is considered. In a study of low-income women in managed care in California, mentioned previously, focus-group participants wanted more attention to be paid to health promotion.[13] They identified nutrition counseling, weight management, and exercise as areas that were not adequately addressed by health care providers.

The importance of health promotion programs and activities for women is evident. Health behaviors such as smoking, diet, exercise, and alcohol consumption are responsible for a significant portion of premature death and disease. Among California women ages 18 and older in 1993-94, 17% smoked (with higher rates seen for white and black women than for Asian women and Latinas), 24% were obese, 22% did not engage in regular exercise, and 8% reported binge-drinking behavior.[14]

What is often less understood is the importance of activities that promote mental health. Mental health status also plays a crucial role in women's overall physical health and social and economic well-being, yet mental health programs are less integrated into managed care plans than smoking-cessation and nutrition services. The strain of coordinating family, children, and work activities exerts a toll. Women in the previously mentioned focus group study stated the need for more help with stress management; they discussed the role that stress played in their lives, and they expressed the need for more information and programs that would help them handle this stress.[15]

While men and women generally experience similar rates of mental illness, women have higher rates of depression and eating disorders. Studies have estimated that the direct medical morbidity costs for depression amount to between $12 billion and $23.8 billion. The costs of depression are similar to those of other major medical illnesses.[16]

Education Approaches Used to Provide Health Information and Promotion

Table 4 lists the approaches used by managed care plans to provide health education to their enrollees. Most commonly used (by more than three-fourths) were print materials (brochures and newsletters), health education classes, educational videos, and self-care materials. About 60% of plans reported using health risk appraisals, Internet Web sites, 24-hour telephone health advisors, and health promotion counseling. With the heavy reliance on print materials, it is important that plans gear the material to the range of educational levels of plan members.

Table 4: Educational Approaches Used to Provide Health Information and Promotion, Commercial Managed Care Plans, California, 1997

Educational Approaches	Percent of Plans That Use This Approach	Percent of Plans That Do Not Use This Approach	Number of Plans That Reported Information
Brochures	89%	7%	26
Health education classes	82%	15%	26
Newsletter	82%	7%	24
Educational videos	74%	19%	25
Self-care materials/books	78%	19%	26
Health risk appraisals	59%	26%	23
Internet Web sites	56%	33%	24
Health promotion counseling	56%	33%	24
24-hour telephone health advisor	56%	37%	25
Total number of plans			**27**

Well-Woman Benefit

In addition to the standard benefit offered, information about well-woman benefits was also obtained from the health care plans. Nearly two-thirds of the commercial managed care plans surveyed reported that they offered a well-woman benefit (Table 5). For all of the plans that offered this benefit, services were defined as an annual obstetric/gynecologic visit for breast and cervical cancer screening. Many plans mentioned that this was a self-referral visit.

Table 5: Well-Woman Benefit, Commercial Managed Care Plans, California, 1997

Percent of Plans With a Well-Woman Benefit	Percent of Plans Without a Well-Woman Benefit	Number of Plans That Reported Information
63%	33%	26
Total number of plans		**27**

As of January 1999, California law allows women limited direct access to an obstetrician-gynecologist for an annual visit without first obtaining a referral from a primary care physician.[17] Approximately 60% of states have passed varying laws that allow women some direct access to an obstetrician-gynecologist. These laws are in response to the gatekeeper structure of managed care plans, in which a primary care physician is the point of referral for other services. These laws allow for a woman to eliminate the primary care referral step and, for at least one annual visit, schedule directly with the obstetrician-gynecologist.

As mentioned above, the surveyed plans' well-woman benefit is focused on reproductive health care; no plans specifically identified any other type of disease risk and health promotion activity as a component of the well-woman visit. This may reflect the separation of reproductive health care services from other types of health care services for women. Yet, women see their health care encompassing not only reproductive needs, but other areas as well. A greater understanding of the gender differences in symptoms, disease occurrence and treatments is needed. The integration of these services into a well-woman benefit is also warranted.

Contracts with Community Providers

To gain information on the use of other service providers external to the health plan, plans were asked about service contracts they have with community providers. Although family planning was not a specific topic of this report, it was included here because there are specific laws that apply to access to these services and it provides a point of contrast. Approximately one-third of plans reported contracts for mammography screening, 41% of plans had contracts with community mental health centers, and 44% with health education telephone information services. The highest proportion of contracts was with family planning centers; nearly two-thirds of plans reported a contract with that type of provider (Table 6).

Table 6: Selected Community Provider Contracts, Commercial Managed Care Plans, California, 1997

Type of Community Provider	Percent of Plans That Have a Contract	Percent of Plans That Do Not Have a Contract	Number of Plans That Reported Information
Mammography screening	33%	63%	26
Community mental health centers	41%	44%	23
Health education telephone services	44%	56%	27
Family planning services	63%	30%	25
Total number of plans			**27**

The reason for the higher contract rates among family planning services may be the result of the "Freedom of Choice" law. This California law requires that all plans with Medi-Cal contracts allow their members the freedom to choose a qualified family planning provider either in or outside the network.[18] Increasing the sphere of family planning providers through contracts broadens a plan's network of providers.

Language Access and Cultural Competency

Linguistic and cultural competency is attracting increasing attention from health care providers because of the demographic diversity in the state. Women's health care often involves sensitive issues and culturally driven norms about health, treatment, reproduction, and sexuality. It is difficult enough for many women to discuss health-related issues with providers speaking the same language. For those women whose health care providers speak a different one, the barriers are often magnified.

The majority of the commercial plans surveyed report that they offered health promotion and education materials in languages other than English (88%). The most frequently mentioned language was Spanish, with 77% of plans reporting materials in this language. Of 23 plans that responded, 69% reported that they had professional interpreters available to clients, while 19% reported that they did not. These interpreting services ranged from trained bilingual staff to consumer access to bilingual telephone personnel.

A recent study underscored the importance of interpreters. In the emergency department of an urban hospital, when interpreters were used for Spanish-speaking patients, the patients' understanding of their diagnosis and treatment plans improved.[19] The study also found that in about one-third of the cases, interpreters were not called when the patient thought they should have been.

Attempts at bridging the cultural gap by providing interpreters will improve patient access to health care and increase patient satisfaction; however, there is still a need to learn about a patient's culture to improve clinical effectiveness.

Clinical Preventive Service Guidelines Used by Plans

Plans were asked about the guidelines they follow, if any, to help establish their recommendations for screenings and screening intervals (Table 7).

Table 7: Clinical Preventive Guidelines Used, Commercial Managed Care Plans, California, 1997

Guidelines	Percent of Plans That Use the Guidelines	Percent of Plans That Do Not Use the Guidelines	Number of Plans That Reported Information
U.S. Preventive Services Task Force	85%	7%	25
American College of Obstetricians and Gynecologists	70%	18%	24
Agency for Health Care Policy and Research	70%	18%	24
American Cancer Society	52%	26%	21
National Cancer Institute	41%	37%	21
Academy of Preventive Medicine	22%	59%	22
Health plan developed guidelines	74%	15%	24
Total number of plans			**27**

Many plans follow more than one source of information to establish their clinical preventive guidelines. The vast majority of plans use the preventive guidelines established by the U.S. Preventive Services Task Force. (The U.S. Preventive Services guidelines were used in the development of the Pacific Business Group on Health preventive care guidelines, developed at the end of 1997 and endorsed by several managed care plans.) Also in common use are guidelines from the American College of Obstetricians and Gynecologists, the Agency for Health Care Policy and Research, and those developed by the actual health plans. Less commonly used were those from the American Cancer Society and the Academy of Preventive Medicine.

Guidelines assist in determining the interval at which screenings will be covered by health care plans, and therefore influence the practices followed by different providers. There is not always a consensus among the guideline-writing organizations as to the most appropriate screening interval.[20] For example, mammography screening for women under 50 years of age is recommended by the American Cancer Society, the American College of Obstetricians and Gynecologists, the American Medical Association, and the National Cancer Institute, but not the American College of Preventive Medicine or the U.S. Preventive Services Task Force.

Health Risk Assessment

Approximately half of the plans (46%) reported that they had their own protocols for assessing the risk factors of individual members. (These were protocols that were either used by the plan or provided to contracted practitioners.) Approximately 30%-40% of plans reported that they had protocols for assessing smoking, dietary habits, obesity, alcohol use, and drug use.

Plans were also asked about assessment of domestic violence, an often hidden problem. Far fewer plans had established protocols for this: 19% reported having their own assessment for this risk.

In a study of large employers, the Washington Business Group on Health (WBGH) found that 20% of HMOs it contracted with had preventive screenings for domestic violence.[21] Overall, domestic violence appears to be one of the least-likely-to-be-covered screenings in our sample, as well as in the WBGH study. It should be noted, though, that domestic violence prevention has recently been gaining broader attention from both providers and plans.

Mental Health/Substance Abuse Assessment

The plan representatives were asked if they had clinical guidelines for assessing the mental health and substance abuse problems of their members. Table 8 presents the percentages of those reporting that they assessed, and of those reporting that they did not assess. Some of the plans were not able to report this information; the non-reporting plans all had mental health/substance abuse carved out, although several plans with carve-outs were able to provide information. All of the plans that had some level of integration of mental health/substance abuse services had data on assessments.

Table 8: Mental Health/Substance Abuse Assessment Protocols Used by Commercial Managed Care Plans, California, 1997

Assessment Area	Percent of Plans That Assess	Percent of Plans That Do Not Assess	Number of Plans That Reported Information
Depression	59%	22%	22
Anxiety disorders	33%	44%	21
Eating disorders	26%	52%	21
Domestic violence	15%	59%	20
Substance abuse	41%	37%	21
Total number of plans			**27**

Approximately 60% of commercial plans reported that they used guidelines to assess for depression, with 22% reporting no guidelines. This was the most common area where guidelines existed. Protocols to assess for other behavioral and social problems were much less frequent. More than one-third did not have protocols to assess for substance abuse or anxiety disorders. More than half did not have them for eating disorders or domestic violence, which are particularly important areas for women. These are areas where it is often difficult for women to initiate discussion, and are topics that are more likely than others to go unnoticed by health professionals.

Incentives to Providers

Slightly more than one-third of plans reported offering financial incentives to physicians to increase the utilization of clinical preventive services for their patients. Among those reporting an incentive (10 plans), the most common form was a bonus to the medical group; that was offered by six plans. Only one commercial plan offered a bonus to the individual physician, and three plans reported other types of incentives.

Patient or Physician Reminder Systems for Preventive Services

The majority of plans reported using reminder systems such as letters, phone calls, and postcards sent to enrollees to utilize preventive services (Table 9). Eighty-two percent of plans (22 plans) reported that they used a reminder to the member from the health plan. Seventy percent (19 plans) used reminders to the physician from the health plan. There was no consensus among the plans as to which method they thought was most effective in increasing the compliance rate for recommended preventive services.

Table 9: Patient or Physician Reminder Systems for Preventive Services, Commercial Managed Care Plans, California, 1997

Reminder Approach	Percent of Plans That Use This Approach	Percent of Plans That Do Not Use This Approach	Number of Plans That Reported Information
Reminder to member from the health plan	82%	19%	27
Reminder to physician from the health plan	70%	30%	27
Total number of plans			**27**

More plans indicated that a reminder to the member was more effective than a reminder to the physician, and a few indicated that both were equally useful. Other approaches were mentioned as well, including targeted reminders to the member, physician, and the plan's medical director from the contracted medical group; a direct reminder from the physician to the member (by passing the plan); user-friendly tools for physicians; and in-service training and education for physicians. Reminders are particularly useful for women due to the importance of screening services such as Pap tests and mammograms.

Provider Perspectives on Ways to Improve Provision of Prevention Services

Asked about ways to improve the provision of preventive services to women, the most frequent suggestions from the physicians interviewed were to provide adequate reimbursement for these services, to allow time for the development of personal relationships with patients, to obtain assistance from the plans in keeping track of which patients were due for screenings, and to have easier access to educational materials for their patients.

Reporting of Process and Outcome Indicators

The National Committee for Quality Assurance (NCQA) has established a core set of quality performance measures, called Health Plan Employer Data and Information Set (HEDIS), to assess the effectiveness of health plans. Among the HEDIS measures asked about in this study, plans were most likely to collect information on the availability of primary care physicians, member satisfaction, cervical cancer screening, and mammography screening (Table 10).

Table 10: Reporting of Selected Process and Outcome Indicators in Commercial Managed Care Plans, California, 1997

Measures Reported	Percent of Plans That Report Measure	Percent of Plans That Do Not Report Measure	Number of Plans That Reported Information
Cervical cancer screening	89%	11%	27
Mammography screening	85%	15%	27
Advising smokers to quit	67%	26%	25
Availability of primary care providers	93%	7%	27
Availability of mental health and chemical dependency providers	78%	19%	26
Readmission for selected mental health disorders	67%	26%	25
Readmission for chemical dependency	70%	22%	25
Member satisfaction survey	89%	11%	27
Total number of plans			**27**

Less commonly collected, by approximately three-fourths of health plans, were HEDIS measures related to chemical dependency, mental health, and smoking.

Collaboration with County or State Agencies

Collaboration between commercial managed care plans and county and state health departments is occurring to some degree. Table 11 shows that for the areas on which we requested information, approximately one-third of plans reported collaborative involvement related to domestic violence, smoking cessation, substance abuse prevention, HIV prevention, and STD screening. Slightly less than one-fourth reported collaboration in breast and cervical cancer screening.

Table 11: Collaboration with County and State Health Departments in Commercial Managed Care Plans, California, 1997

Collaborative Area	Percent of Plans That Report Collaboration	Percent of Plans That Report No Collaboration	Percent of Plans That Reported Information
Women's health coalitions	33%	52%	23
Breast and cervical cancer screening	22%	63%	23
Domestic violence education and prevention	33%	52%	23
Smoking cessation	30%	59%	24
Substance abuse prevention	30%	56%	23
HIV screening and/or treatment	37%	48%	23
STD screening and/or treatment	33%	52%	23
Total number of plans			**27**

Women's Health in Commercial Managed Care Plans

There is some degree of integration of women's health issues in managed care plans; however, there is considerable room for expansion. In the majority of plans (63%), the medical director has primary organizational responsibility for women's health. Health education directors also assume some of this responsibility (15% of plans, Table 12). Less common is for this role to be assumed by the nursing director (4% of plans). In 15% of plans, no one person is designated as having organizational responsibility for women's health services.

Table 12: Organizational Responsibility for Women's Health, Commercial Managed Care Plans, California, 1997

Organizational Responsiblity for Women's Health	Percent* and Number of Plans	
Medical director	63%	17
Health education director	15%	4
Nursing director	4%	1
No one designated	15%	4
No response	4%	1
Total	**100%**	**27**

*Percentages do not add to 100% because of rounding.

Table 13: Updating Mechanisms in Commercial Managed Care Plans, California, 1997

Approach	Percent of Plans That Have Mechanism	Percent of Plans That Do Not Have Mechanism	Number of Plans That Reported Information
To update providers about women's health	85%	15%	27
To educate women about health behaviors and prevention	78%	22%	27
Total number of plans			**27**

The majority of plans reported that they had a way to disseminate information to providers and consumers on women's health issues (Table 13). Eighty-five percent of plans reported that they had a system to update providers about new women's health issues. Slightly more than three-fourths of plans (78%) reported that they had in place a way to educate women about healthy behaviors and prevention strategies.

Best Practices in Women's Health

Plans were asked to identify their three best women's health programs. Approximately half of the respondents mentioned breast and cervical cancer screenings, reminder systems for breast and cervical cancer, direct access to obstetricians and gynecologists, and pregnancy-related services. Also mentioned, but by far fewer plans, were diabetes management, smoking cessation, HIV prevention, integrated preventive health services, osteoporosis management, hormone replacement therapy programs, and health fairs. Clearly, services related to reproductive health care were considered by most plans to be their model programs.

Medi-Cal Managed Care: Local Initiatives and County Organized Health Systems

The financing and delivery of Medi-Cal services has gone through significant changes during the past decade. There's been a shift to managed care during the 1990s; approximately 40% of Medi-Cal beneficiaries are currently enrolled in a form of managed care in California.[22] This section looks at health promotion and disease prevention services in two types of Medi-Cal managed care systems: local initiatives under the two-plan model (LIs), and county organized health systems (COHSs). Geographic managed care (GMC) plans were not surveyed.

The two-plan model allows enrollees to choose between a mainstream, commercial managed care organization, which is usually a larger statewide HMO, or a public entity (known as the local initiative). County organized health systems are a managed care model established in 1982. At the time of the survey, local initiatives in eight counties were established and surveyed. Five county organized health systems were operating and four responded to the survey. The majority of specialty mental health and substance abuse services are carved out of the managed care plans in the two-plan model, and are organized through the county in the COHS; therefore, LIs/COHSs were not asked about these services. This section on Medi-Cal managed care is not meant to be an evaluation of these plans, but rather a look at the provision of selected services only with regard to their effect on selected aspects of women's health.

Services and Programs Covered

Coverage for Preventive Screenings, Health Promotion, and Health Education

All of the responding LIs/COHSs reported that they covered the standard clinical preventive screenings listed (Table 14), and all had some type of health promotion and health education program. Medi-Cal requires that plans serving Medi-Cal clients offer preventive health care services and patient education that meet the Knox-Keene requirements.[23]

Table 14: Coverage of Health Promotion and Disease Prevention Services, Local Initiatives and County Organized Health Systems, California, 1997

Covered Benefits	Percent of Plans That Cover	Number of Plans That Reported Information
Screening		
Pap smear	100%	12
Screening mammography	100%	12
Routine physical examination	100%	12
Health promotion programs	100%	12
Health education	100%	12
Total number of plans		**12**

Coverage of Specific Health Promotion Programs

There was variability, however, in which health promotion programs were most likely to be offered. The most commonly offered health promotion services (offered by more than three-fourths of plans) were smoking cessation and nutritional counseling programs (Table 15). Weight loss programs were offered by slightly more than half of the plans. Less frequently provided by the LIs/COHSs were stress reduction, mental health promotion, and substance abuse prevention services.

A recent study showed that low-income women enrolled in managed care plans in California did want better access to stress reduction and mental health promotion services, as well as programs on nutrition and weight loss.[24]

Table 15: Coverage of Selected Health Promotion Programs, Local Initiatives and County Organized Health Plans, California, 1997

Health Promotion Programs	Percent of Plans That Offer	Percent of Plans That Do Not Offer	Number of Plans That Reported Information
Smoking cessation	83%	17%	12
Nutritional counseling	83%	8%	11
Weight loss program	58%	33%	11
Stress reduction classes	25%	67%	11
Mental health promotion	25%	58%	10
Substance abuse prevention	25%	58%	10
Total number of plans			**12**

Education Approaches Used to Provide Health Information and Promotion Services

The LIs/COHSs reported that they used several different approaches to provide health information and promotion services to members. Table 16 lists, in descending order, those strategies. The State Department of Health Services mandates health education outreach but not the specific approach to be used.

Table 16: Educational Approaches Used to Provide Health Information and Promotion, Local Initiatives and County Organized Health Plans, California, 1997

Educational Approaches	Percent of Plans That Use Approach	Percent of Plans That Do Not Use Approach	Number of Plans That Reported Information
Newsletters	92%	--	11
Brochures	83%	--	10
Health education classes	83%	8%	11
Health promotion counseling	67%	25%	11
24-hour telephone health advisor	67%	17%	10
Self-care materials/books	67%	25%	11
Health risk appraisal	58%	33%	11
Educational videos	50%	42%	11
Internet Web sites	33%	58%	11
Total number of plans			**12**

Most frequently reported (by more than three-fourths of plans) were newsletters, brochures, and health education classes. The plans' reliance on written material emphasizes the importance of translation into languages used by the plans' members and of appropriate reading levels to reach populations with low literacy. Other common approaches (reported by two-thirds of plans) were health promotion counseling, 24-hour telephone personal health advisors, and self-care materials and books. Less frequently used were health risk appraisals, educational videos, and health plan Web sites.

Well-Woman Benefit

Forty-two percent of LIs/COHSs reported that they offered a well-woman benefit, but the information about this was not well specified (Table 17). Unlike the commercial plans that offered this service, this benefit was not consistently defined as a

preventive screening package. One plan not currently providing this benefit indicated that it wanted to provide the service in the future.

Table 17: Well-Woman Benefit, Local Initiatives and County Organized Health Plans, California, 1997

Percent of Plans with a Well-Woman Benefit	Percent of Plans Without a Well-Woman Benefit	Number of Plans That Reported Information
42%	58%	12
Total number of plans		**12**

Medi-Cal enrollees are allowed to self-refer for comprehensive reproductive health services. Plan authorization is not required, and in- and out-of-network providers can be used. (At the time of enrollment, Medi-Cal enrollees must be informed of their right to directly obtain family planning and other reproductive health services from a provider of their choice.)[25] Anecdotal information in California suggests that Medi-Cal enrollees are not always informed in a clear and culturally appropriate way of this right, and that community providers are experiencing some difficulty both in getting referrals from managed care plans and in getting timely reimbursement from those plans once services are provided.[26]

Contracts with Community Providers

Many of the LIs/COHSs reported that they had contracts with community providers. Three-fourths of LIs/COHSs reported that they had contracts with community health centers (Table 18). Traditionally, these providers have served communities that have limited access to care. These contracts with community health centers are important in linking women with familiar care providers.

Table 18: Selected Community Provider Contracts, Local Initiatives and County Organized Health Plans, California, 1997

Type of Community Provider	Percent of Plans That Have Contract	Percent of Plans That Do Not Have Contract	Number of Plans That Reported Information
Community health centers	75%	--	9
Community mental health centers	42%	58%	12
Family planning centers	83%	8%	11
Health education telephone information centers	50%	50%	12
Total number of plans			**12**

Another important contracting source was with family planning centers; 83% of Medi-Cal plans had contracts. The Freedom of Choice law, enacted in 1987, allows states to "carve out" family planning services and permits women enrolled in Medicaid managed care plans to obtain services from any qualified in- or out-of-network family planning provider. No prior authorization is required to access these services, which include pregnancy testing, contraceptives, and HIV and STD screening. Therefore, it is in the interest of the Medi-Cal plan to broaden its provider network for these services.

Language Access and Cultural Competency

The California Department of Health Services has set guidelines for health care plans serving Medi-Cal recipients, mandating that cultural and linguistic services be provided for threshold languages no later than the year 1999. According to DHS, "Threshold languages in each county are designed by DHS. These are primary languages spoken by Limited English Proficient (LEP) population groups meeting a numeric threshold of 3,000 eligible beneficiaries residing in a county. Additionally, languages spoken by a population of eligible LEP beneficiaries residing in a county, who meet the concentration standard of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes, are considered threshold languages for a county."[27]

Although this study did not set out to examine cultural competency, we did get basic information on this important aspect of service provision. In addition to English, all of the LIs/COHSs reported that they offered health promotion and education materials in Spanish. One-fourth of these plans reported they offered these services in Chinese, and one-third offered them in Vietnamese. Thai, Cambodian, and Farsi were "other" languages in which health promotion materials were made available, by at least one of the plans. Almost all plans (92%, 11 plans) reported that they had professional interpreters available to clients.

Clinical Preventive Service Guidelines Used by Plans

Asked what guidelines they followed for the provision of clinical preventive services (Table 19), the LIs/COHSs most commonly cited those from the U.S. Preventive Services Task Force and the American College of Obstetrics and Gynecology (ACOG), mentioned by nearly all plans (92%). Guidelines from the Agency for Health Care Policy and Research also figured prominently. Less frequently used were guidelines from the American Cancer Society and the National Cancer Institute. Approximately three-fourths of local initiatives/COHS mentioned that they also used their own health plan-developed guidelines.

Table 19: Clinical Preventive Guidelines Used, Local Initiatives and County Organized Health Systems, California, 1997

Guideline	Percent of Plans That Use the Guideline	Percent of Plans That Do Not Use the Guideline	Number of Plans That Reported Information
U.S. Prevention Services Task Force	92%	8%	12
American College of Obstetricians and Gynecologists	92%	8%	12
Health plan-developed guidelines	73%	27%	11
Agency for Health Care Policy & Research (AHCPR)	67%	33%	12
American Cancer Society	42%	42%	10
National Cancer Institute	42%	42%	10
Academy of Preventive Medicine	33%	50%	10
Total number of plans			**12**

The high percentage of plans reporting that they followed the U.S. Preventive Services Task Force guidelines was not surprising; local initiatives follow these recommended guidelines for periodic health examinations.

Health Risk Assessment

One-third of LIs/COHSs stated that they had developed specific protocols for assessing the behavioral risk factors of individual members. Overall, one-fourth of plans had developed these for smoking, dietary habits, obesity, alcohol use, drug use, and domestic violence. Three plans that did not report having their own protocols reported that the California Department of Health Services was developing a health assessment tool to be used by the plans. This age-specific health education tool will assess a variety of health risk behaviors. Based on the U.S. Preventive Services Task Force guidelines, Healthy People 2000, and state-specific data, it is designed to target areas that are amenable to change through education, counseling, referral and follow-up.

Mental Health/Substance Abuse Assessment

Guidelines for assessment of mental health, substance abuse, or social problems were less frequent than assessment for health behaviors (Table 20). Most commonly reported were guidelines for assessment of depression, reported by five out of 12 plans. Much less common were guidelines for assessment of domestic violence, eating disorders or substance abuse, with 75% or more plans having no assessment tools in place. Although these services were often carved out in the local initiatives, often the primary care physician is the first point of contact for these issues.

Table 20: Mental Health/Substance Abuse Assessment Protocols Used by Local Initiatives and County Organized Health Systems, California, 1997

Assessment Area	Percent of Plans That Access	Percent of Plans That Do Not Access	Number of Plans That Reported Information
Depression	42%	58%	12
Anxiety disorders	17%	83%	12
Eating disorders	25%	75%	12
Domestic violence	17%	83%	12
Substance abuse	17%	83%	12
Total number of plans			**12**

Incentives to Providers

Monetary incentives were not commonly used by plans to encourage physicians to provide more preventive services. One-fourth of LIs/COHSs reported that they offered financial incentives to physicians (either to the individual physician or the medical group) to increase utilization of clinical preventive services.

Patient or Physician Reminder Systems for Preventive Services

Although incentives were not widely used, reminder systems for preventive services were much more common. Eighty-three percent of LIs/COHSs reported that they used a reminder to the member from the plan and 75% used a reminder to the physician from the health plan (Table 21). As to whether contacting the member or the physician was more effective in increasing compliance with recommended preventive screening, half responded that sending a reminder to the member from the plan was a better method for increasing compliance.

Table 21: Patient or Physician Reminder Systems for Preventive Services, Local Initiatives and County Organized Health Systems, California, 1997

Reminder Approach	Percent of Plans That Use This Approach	Percent of Plans That Do Not Use This Approach	Number of Plans That Reported Information
Reminder to member from the health plan	83%	17%	12
Reminder to physician from the health plan	75%	25%	12

One plan mentioned, however, that reminder systems were not effective because the enrollee population changed frequently, making it difficult for the plan to maintain correct phone numbers and addresses.

Reporting of Process and Outcome Indicators

The vast majority (92%) of LIs/COHSs stated that they reported cervical cancer and mammography screening according to HEDIS measures (Table 22). But certain indicators were much less frequently collected. Information on advising smokers to quit is collected by only 17% of plans (two plans); this may have been due to the fact that it was counseling, rather than a procedure, that was conducted.

Most plans (83%) reported on the availability of primary care providers. Very few plans, however, reported on the availability of mental health or substance abuse providers, because these were primarily carved out, and in a separate system of care.

Most plans (83%) also collected information on how satisfied members were with care. Twenty-five percent of plans reported that they provided HEDIS information to their members.

Table 22: Reporting of Selected Process and Outcome Indicators in Local Initiatives and County Organized Health Plans, California, 1997

Measures	Percent of Plans That Report Measure	Percent of Plans That Do Not Report Measure	Number of Plans That Reported Information
Cervical cancer screening	92%	8%	12
Mammography screening	92%	8%	12
Advising smokers to quit	17%	75%	11
Availability of primary care providers	83%	17%	12
Availability of mental health and chemical dependency providers	17%	75%	11
Readmission for selected mental health disorders	17%	75%	11
Readmission for chemical dependency	8%	83%	11
Member satisfaction survey	83%	17%	12
Total number of plans			**12**

Women's Health in Managed Care

The medical director had primary organizational responsibility for women's health in 42% of the LIs/COHSs (Table 23). In 25%, the medical director and another staff member had this responsibility. In one-third of plans, no one assumed this role.

Two-thirds of plans reported that they had a mechanism to update providers on new women's health issues. The majority of plans (83%) reported that they had a mechanism to educate women about health behaviors and prevention strategies (Table 24).

Table 23: Organizational Responsibility for Women's Health, Local Initiatives and County Organized Health Systems, California, 1997

Organizational Responsiblity for Women's Health	Percent and Number of Plans	
Medical doctor	42%	5
Combination of staff	25%	3
No one designated	33%	4
Total number of plans		**12**

Table 24: Updating Mechanisms in Local Initiatives and County Organized Health Systems, California, 1997

Approach	Percent of Plans that Have Mechanism	Percent of Plans That Do Not Have Mechanism	Number of Plans That Reported Information
To update providers about women's health	67%	33%	12
To educate women about health behaviors and prevention	83%	17%	12
Total number of plans			**12**

Plans were also asked about their best programs in women's health. Most plans' responses focused on some aspect of reproductive health care, such as prenatal risk assessment, perinatal case management, reminder systems for breast cancer screening and other screenings, programs targeted to teens, and direct access to STD and contraceptive services.

Key Findings and Conclusions

There are many steps involved in creating a health care system responsive to the needs of women. Historically, under the fee-for-service system, there were gaps in the care provided, particularly in terms of preventive health, health promotion, mental health and substance abuse services. This study has focused on the extent to which managed care is addressing these gaps. The report provides a description of how managed care is organized in California, and what services for women are emphasized. It draws on information provided by the managed care organizations themselves, as well as providers working within the managed care system. The following summarizes the main conclusions from the study:

The Perspective on Women's Health Remains Limited

Managed care has not yet fostered the development of a cohesive and comprehensive approach to women's health care delivery. Fragmentation of services continues to exist throughout the system. The well-woman benefit, while sounding like a comprehensive approach to women's health care, primarily focuses on access to reproductive health care. When asked to describe this benefit, all respondents characterized it as coverage for preventive care related to reproductive health. No other health risk or health promotion activities were identified as a component of the well-woman visit, such as routine cholesterol screenings, other non-reproductive cancer screenings, or other routine prevention services, although women see their health care needs as encompassing these and much more.

Preventive Health Services Are Offered by Most Plans

Women's preventive health services appear to be offered by most managed care plans throughout California. In addition to clinical preventive screenings, health promotion activities were offered by many plans. Smoking cessation and nutrition counseling are the most commonly covered, although other studies indicate that participation in these programs is low. Managed care plans need to do more to increase participation and use of these services. Women express a strong interest in these programs, especially nutrition counseling, weight management, and exercise programs. Yet weight reduction, stress reduction, mental health promotion, and substance abuse prevention are not widely offered. Managed care plans need to conduct more outreach, improve access, and give greater support to these important health promotion activities.

Carve-Outs Can Increase Fragmentation

Mental health and substance abuse services are often carved out and external to the managed care plan and usual source of care in commercial plans. Although laws have been enacted to preserve and protect confidentiality and access to these sensitive services, carve-outs may have unintended consequences. In commercial plans, primary care providers reported concerns with referring patients to providers they were not familiar with, as well as a lack of mental health and substance abuse providers to whom to refer patients. In addition, primary care providers often did not have access to information about the mental health or substance abuse treatment their patients may have been receiving unless they were informed by the patient herself. Furthermore, co-payments are often high for these services, which may serve as a deterrent to those seeking care. When it comes to mental health and substance abuse services, managed care plans need to explore more effective ways to increase access and preserve continuity of care while protecting patient confidentiality. Legislation would address some of the issues related to parity by requiring diagnosis and treatment of mental illness under the same rates, terms, and conditions as other medical conditions.

Preventive and Health Promotion Services Need to Be Expanded

Coverage for services that are important to women, but that extend beyond traditional medical care services, is limited. Focus groups conducted in California with low-income women in managed care found that women wanted a more preventive approach to their health care that includes regular health promotion assessments and reminders for preventive health screenings. These same women wanted more attention paid to preventive health behaviors such as smoking, diet and exercise. Furthermore, mental health-related services such as domestic violence prevention, eating disorders, stress reduction, and alcohol and substance abuse, while priorities to many women, were not normally assessed in the health care setting. These services have largely been ignored by managed care. Domestic violence is only recently gaining attention from a few plans.

All Plans Need Stronger Links with Public Health Agencies

Although our goal was not to compare commercial and Medi-Cal managed care plans, each shows some strengths and weaknesses. It appears that the Medi-Cal plans benefit the most from their historic relationship with public health. Public health agencies appear to collaborate primarily with plans with Medi-Cal contracts. Yet, many public health agencies have public education and outreach programs that would be beneficial to all women. All plans, regardless of whether they have Medi-Cal contracts, could benefit from linkages with public health agencies. The experience of the public health agencies and their understanding of population-based

health make collaborative efforts important. This is an area where partnerships between managed care plans and public health agencies could help to strengthen efforts to improve population health.

Conclusion

In closing, this is the first study to document how selected women's health services are being covered and delivered within managed care settings in California. The findings show important accomplishments and significant deficits. Overall, it appears that women's voices have been heard in selected areas. Comprehensive reproductive health services have been protected, providing direct access to an obstetrician/gynecologist and pregnancy-related services, while maintaining confidentiality. Managed care plans cover and promote clinical preventive health services, particularly breast and cervical cancer screening, and smoking and nutrition counseling. But managed care plans need to consider stronger mandates for more comprehensive programs in women's health that will cover a broader range of services throughout the life cycle. Furthermore, coverage for mental health services needs to be extended, co-payments reduced, and a more integrated system of assessment and referral with medical care providers developed. More outcome measures are needed in order to better assess the impact of care on women's health. And more research is needed to better understand how to organize women's health services to optimize health outcomes in managed care settings.

The findings from this study are only a beginning to understanding how managed care has tried to address and organize women's health care services. Many of these findings can be beneficial to other enrollees as well. New models need to be developed that will help to shape a future health delivery system that will be more responsive to women's needs and will more fully engage women in participating in the management and maintenance of their own health care.

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Appendix

Health Plans Surveyed

Aetna U.S. Healthcare
Alameda Alliance for Health
Blue Cross of California
BPS HMO (Viva Health)
CalOPTIMA
CareAmerica Southern California
Chinese Community Health Plan
CIGNA Health Care
Community Health Group
Contra Costa Health Plan
Great American Health Plan
Greater Pacific HMO
Health Net
Health Plan of San Joaquin
Health Plan of the Redwoods
Inland Empire Health Plan
Kaiser Foundation Health Plan
Kern Family Health Care
Lifeguard Health Plan
L.A. Care Health Plan
Maxicare
Molina Medical Center
Monarch Health System
National Health Plan
Omni Healthcare
One Health Plan of California
Pacificare
Prudential
San Francisco Health Plan
Santa Barbara Health Authority
Santa Clara Family Health Plan
Santa Cruz County Health Options
Solano Partnership Health Plan
Tower Health Plan
United Health Care
United Health Plan (Watts Health Foundation)
Universal Care
Ventura County Health Plan
Western Health Advantage

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