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Medicaid Managed Care And STDs: Missed Opportunities To Control The Epidemic

Lack of organizational priority is the major barrier to providing care for those with sexually transmitted diseases in Medicaid.

by Nadereh Pourat, E. Richard Brown, Natasha Razack, and William Kassler

ABSTRACT: We examined the extent to which selected Medicaid managed care organizations (MCOs) promoted certain prevention and control services for sexually transmitted diseases (STDs) and the potential influence of health plans and medical groups on the delivery of STD care by primary care providers (PCPs) in seven large U.S. cities. Low-cost clinical services were routinely performed by PCPs, but higher-cost services were less often provided. Lack of organizational priority to promote STD prevention and control is a major barrier even for those MCOs that serve this high-risk, low-income population. Stronger incentives and legally binding provisions in Medicaid contracts are needed to promote adherence to standards of STD care.

THE HIGH RATE of sexually transmitted diseases (STDs) in the United States and the higher prevalence of bacterial STDs among the populations that include large numbers of Medicaid beneficiaries suggest that STDs should be an important focus of disease prevention for Medicaid managed care organizations (MCOs). The high number and proportion of Medicaid beneficiaries who are enrolled in MCOs underscore the importance of Medicaid MCOs' adopting and implementing effective policies and services to diagnose, treat, and prevent STDs. In this paper we examine the STD policies of Medicaid MCOs and their contracted medical groups (CMGs) in seven cities with a high prevalence of chlamydia, gonorrhea, and syphilis and explore whether primary care providers' (PCPs') STD practices may be influenced by the presence of STD policies in the managed care plans and medical groups.

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Background

■ **STD prevalence.** STDs are among the most common infectious diseases in the United States, although most Americans do not realize the extent of the epidemic.¹ An estimated fifteen million new STD cases occur in the United States each year, with approximately one-quarter of these new infections affecting teenagers.² The burden of illness from STDs is exacerbated by infertility, pregnancy complications, cancer, and a greater susceptibility to HIV infection.³

The risk of certain STDs is higher for adolescents, women, infants, some minority racial and ethnic groups, and the poor—in short, a large proportion of the Medicaid population.⁴ STD services should be an important component of Medicaid programs because for low-income women, adolescents, and children, Medicaid is the primary payer of periodic health screening, prenatal care, and family planning services.⁵

■ **Medicaid MCO enrollment.** Many states have enrolled Medicaid beneficiaries in MCOs to control Medicaid program costs and improve access; 56.7 percent of all Medicaid beneficiaries were enrolled in MCOs in 2000.⁶ This enrollment was expected to encourage a public health approach to disease prevention and health promotion.⁷ MCOs could use their provider networks, contractual relationships, and client-tracking technologies to improve coordination, promote continuity of patient care, and improve its quality. Some analysts have argued that MCOs have incentives to adopt and implement STD prevention strategies because by reducing infectious diseases, they could control their costs more effectively.⁸ In addition, state contracts provide opportunities to hold MCOs accountable for specific performance standards.

The number of MCOs serving Medicaid beneficiaries rose from 166 in 1993 to 556 in 2000, including 208 commercial plans that served 8.4 million beneficiaries in 2000.⁹ The rapid entry of MCOs into the Medicaid market has generated concerns about the relative inexperience of these organizations in serving the Medicaid population, which differs from commercial enrollees. Medicaid beneficiaries experience more fluctuations in coverage.¹⁰ They also experience an apparently higher risk of STDs compared with typical managed care enrollees and thus may require more effective diagnostic techniques and treatment regimens.¹¹ However, the variation in contractual relationships and multiple plan contracts per provider limits plans' ability to enforce effective STD practice policies among these providers.¹²

■ **Existing research.** Despite the importance of this topic, existing research is limited. A comprehensive study of state Medicaid MCO contracts has identified the extent of STD-specific elements in such contracts for a number of states.¹³ However, we have found no other studies that have assessed whether MCOs are promoting recommended STD practice guidelines actively or that have examined the extent to which there is congruence among formal plan or group policies and PCPs' actual practices. The crucial first step in developing effective programs to address this per-

sistent epidemic is to gain a better understanding of MCOs' level of involvement in promoting STD prevention and treatment.

Study Methods

■ **Selection of STD practice guidelines.** We addressed the absence of a single “gold standard” for evaluating STD practices by developing a list of selected guidelines and practice protocols. Most were based on recommendations of the U.S. Preventive Services Task Force or the Centers for Disease Control and Prevention (CDC); one guideline was from the Institute of Medicine and one from the American Medical Association Guidelines for Adolescent Preventive Services (GAPS). Independent experts have recommended similar protocols.¹⁴ These practice guidelines were selected if there was a clear and strong recommendation that had been published by at least one authoritative body. An advisory panel of STD experts from Medicaid and commercial MCOs, a local health department, a state health department, a federal agency, and an advocacy organization reviewed a draft of the guidelines. The final list of guidelines appears in Exhibit 1.

EXHIBIT 1

Promotion And Practice Of STD Control And Prevention Guidelines In Medicaid Managed Care Plans

Guideline	MCO recommends	CMG recommends	PCP practices
Provide preventive counseling while taking sexual history ^a	57%	81%	98%
Presumptively treat chlamydia in presence of gonorrhea ^a	14	79	94
Use single-dose therapies (Azithromycin) for chlamydia ^a	40	68	78
Direct observation of oral dosage of patients for chlamydia or gonorrhea ^a	25	50	53
Treat minors without parental/guardian consent ^a	75	79	81
Screen sexually active adolescents annually for chlamydia ^{b,c}	15	45	55
Screen women ages 20–24 annually for chlamydia ^{a,b}	10	50	47
Conduct prenatal syphilis screening ^a	71	93	94
Advise infected patients to notify partners and urge testing ^a	33	94	98
Alert public health department to do partner notification ^a	57	79	65
Test and treat partner regardless of plan membership or reimbursement ^d	10	61	62

SOURCES: See below.

NOTE: STD is sexually transmitted disease. MCO is managed care organization. CMG is contracted medical group. PCP is primary care provider.

^a Centers for Disease Control and Prevention, “1998 Guidelines for Treatment of Sexually Transmitted Diseases,” *Morbidity and Mortality Weekly Report* 47, no. RR-1 (1998): 1–116.

^b U.S. Preventive Services Task Force, *Guide to Clinical Preventive Services*, 2d ed. (Alexandria, Va.: International Publishing, 1996).

^c American Medical Association, *Guidelines for Adolescent Preventive Services (GAPS): Recommendations and Rationale* (Chicago: American Medical Association, 1994).

^d Institute of Medicine, *The Hidden Epidemic: Confronting Sexually Transmitted Diseases* (Washington: National Academy Press, 1997).

■ **Plan selection.** We selected MCOs in seven large U.S. cities that had very high rates of reported syphilis, gonorrhea, and chlamydia cases and also had more than half of their Medicaid population enrolled in managed care. These cities included Baltimore, MD; Charlotte, NC; Dayton, OH; Louisville, KY; Memphis, TN; Norfolk, VA; and Oklahoma City, OK. In each city we selected MCOs that served the largest proportions of Medicaid beneficiaries, if more than one plan was serving this population. We randomly selected up to five CMGs associated with those MCOs. We then selected PCPs associated with those CMGs, enabling us to relate information and responses across three associated tiers: MCO, CMG, and PCP. Our samples of these three tiers were systematically selected to reflect diversity among Medicaid-serving MCOs and their providers and not to be representative of all Medicaid plans, groups, and providers.

■ **Interview protocol.** We conducted telephone interviews with the medical directors, or their designated respondents, of the MCOs and CMGs, and we interviewed practitioners who were PCPs. Twenty-one MCOs participated out of twenty-four contacted (88 percent response rate). Fourteen of the twenty-one plan respondents (67 percent) were medical directors, while the rest were utilization/quality managers and Medicaid program managers. Nearly two-thirds of the plans we studied reported that 75 percent or more of their enrollees were Medicaid beneficiaries, while 29 percent reported that fewer than one-fourth of their enrollees were Medicaid patients (Exhibit 2). Three plans in the sample were for-profit organizations and had a smaller share of Medicaid beneficiaries.

We aimed to interview three CMGs for each MCO, selecting those that were significant Medicaid providers. However, six plans declined to supply their provider directories for further CMG and PCP interviews. We compensated for lower participation rates among groups in some MCOs by including additional groups in other MCOs. Thus, instead of three groups per MCO, we interviewed one to five groups in each MCO that agreed to identify its medical groups. We interviewed the medical director or designated alternate in thirty-one CMGs (55 percent response rate). Three-fourths of group respondents were medical directors. Among the medical groups, 66 percent reported that Medicaid recipients accounted for 50 percent or less of their enrolled patients. Two-thirds of CMGs had ten or more PCPs in their groups.

From each CMG, we randomly selected three PCPs who were contracted or employed by these groups, using provider directories supplied by the MCOs. PCPs in some groups refused to participate; they were replaced with providers in other groups, resulting in a range of from one to nine PCPs per group. A total of fifty PCPs were interviewed (45 percent response rate), of whom 70 percent were physicians and 26 percent were nurse practitioners or physician assistants. Almost half (48 percent) had been practicing for fewer than ten years, and 20 percent had twenty or more years of postdegree experience. One in four providers reported that Medicaid recipients constituted more than half of their practice, while 42

EXHIBIT 2 Managed Care Organization (MCO), Contracted Medical Group (CMG), And Primary Care Provider (PCP) Respondent Characteristics

Characteristic	MCO	CMG	PCP
Percent of MCO or CMG enrollees or PCP practice who have Medicaid			
Less than 25 percent	29%	31%	42%
25–50 percent	5	31	31
51–75 percent	5	20	16
More than 75 percent	62	17	12
Type of MCO ownership			
For profit	14%		
Not for profit	86		
Number of PCPs in CMGs			
Fewer than 10		35%	
10 or more		65	
Type of PCP practice			
Solo			12%
Single or multispecialty group			30
Clinic or hospital			54
Other			4
PCP Medicaid reimbursement method			
Fee-for-service			10%
Capitation			66
Both			24
Number of MCO contracts with medical groups			
10 or fewer	38%		
More than 10	62		
Percent female			
	38%	57%	
Percent male			
	62	43	
Average age (years)			
	49	42	

SOURCE: Authors' analysis of a survey of Medicaid managed care organizations, medical groups, and primary care providers conducted by authors.

percent said that they accounted for 25 percent or less of their practice. More than half of the providers in the sample were working in clinics or hospitals, and two-thirds were paid on a capitation basis for their Medicaid patients.

The high refusal rate among the targeted sample populations led to findings that cannot be generalized to the entire Medicaid managed care system. Thus, the findings are considered to be qualitative and mainly used to illustrate and raise issues rather than to draw firm policy conclusions. Data collection occurred between October 1998 and June 1999.

Results

■ **Medicaid MCOs and STD policies.** Sampled Medicaid MCOs were asked whether they recommend STD practice guidelines directly to their PCPs. Plans did not do so consistently, despite the high prevalence of STDs in the cities they served

and in the populations from which they drew their enrollees. Slightly more than half of the surveyed plans recommended that PCPs provide preventive counseling while taking a sexual history (Exhibit 1). Of the other STD practice guidelines, three or fewer plans recommended presumptively treating chlamydia in the presence of gonorrhea, annually screening sexually active adolescents and women ages twenty to twenty-four for chlamydia, or testing and treating sexual partners regardless of plan membership or reimbursement. Recommendations of other practices that could prevent the spread of STDs or enhance patient compliance, such as using single-dose therapies for chlamydia and advising infected patients to notify partners and urge them to get tested, were limited to only 40 percent and 33 percent of the MCOs, respectively.

■ **Medicaid CMGs and STD policies.** Most of the medical groups recommended at least some STD practice guidelines to their PCPs, regardless of the presence of guidelines from their contracted MCOs. More than three-fourths of CMGs recommended preventive counseling while taking a sexual history, presumptively treating chlamydia in the presence of gonorrhea, treating minors for STDs without parental/guardian consent, conducting syphilis screening as part of prenatal care, advising infected patients to notify partners and urge testing, and alerting the public health department to notify partners and urge testing (Exhibit 1). However, half or fewer of the groups recommended directly observing the administration of medication for patients diagnosed with chlamydia or gonorrhea or annually screening sexually active adolescents and young women for chlamydia.

■ **Medicaid PCPs and STD policies.** PCPs reported that they usually followed CDC-recommended STD practices (Exhibit 1). More than 90 percent reported conducting counseling while taking a sexual history, presumptively treating gonorrhea in the presence of chlamydia, conducting syphilis screening as a part of prenatal care, and advising patients to notify their sexual partners.¹⁵

Practices that involve costs to the practitioner, such as the use of more expensive single-dose therapy for chlamydia, treating minors without parental consent, testing and treating sexual partners regardless of plan membership or reimbursement, and alerting the public health department to notify sexual partners, were reported by fewer respondents (62–81 percent). Other STD control practices were reported by about half of the respondents, including direct observation of oral therapy and annual chlamydia screening of adolescents and young women.

■ **Influence of MCO and CMG policies on PCP practices.** PCPs' provision of STD services may be influenced by a number of factors, including the policies of the plans and groups. First, we examined the extent to which PCPs' reporting of practices was consistent with whether the plans and groups with which they were affiliated recommended the practices. We selected forty-five PCPs for whom we had complete information on their affiliated plan or group (thus including information on ten MCOs and nineteen CMGs). Although the small sample sizes and the design of the study do not allow definitive conclusions regarding the factors that influence

providers' practices, some patterns suggest tentative conclusions.

For most of the guidelines, the proportion of PCPs who reported practicing the guideline was not much different whether the plan or group recommended the guideline or not (Exhibit 3). This general pattern suggests that other factors influence PCPs' practice of these guidelines. Broad professional consensus about the desirability or the ease of administration of the guidelines evaluated in this study may help to explain the very high rates of reported practice for several of these guidelines. For example, prenatal syphilis screening was reported by 96 percent of the PCPs if their MCO recommended it versus 88 percent if it did not.

Some recommended practices were far from universal among PCPs, regardless of whether their plan or group had a related policy. More education of PCPs seems necessary to encourage them to treat minors without parental consent and to alert the health department to notify partners of infected patients.

However, the results also indicate that plan and group policies may exert a posi-

EXHIBIT 3
Consistency Between Managed Care Organizations' (MCOs') Or Contracted Medical Groups' (CMGs') Recommendations And Primary Care Providers' (PCPs') Sexually Transmitted Disease (STD) Management Practices

PCP STD management practice	Percent of PCPs using guidelines			
	MCO policy on STD guidelines		CMG policy on STD guidelines	
	MCO recommends	MCO does not	CMG recommends	CMG does not
Provide preventive counseling while taking sexual history	97%	100%	97%	100%
Presumptively treat chlamydia in presence of gonorrhea	75	95	94	91
Use single-dose therapies (Azithromycin) for chlamydia	100	73	82	43
Direct observation of oral dosage of patients for chlamydia or gonorrhea	50	0	40	50
Treat minors without parental/guardian consent	86	77	88	79
Screen sexually active adolescents annually for chlamydia	100	42	82	35
Screen women ages 20–24 annually for chlamydia	0	45	77	28
Conduct prenatal syphilis screening	96	88	94	0
Advise infected patients to notify partners and urge testing	100	97	98	100
Alert public health departments to do partner notification	66	60	67	86
Test and treat partner regardless of plan membership or reimbursement	29	68	46	81

SOURCES: See Exhibit 1.

NOTES: Analysis of MCOs in this exhibit excludes 11 MCOs without CMG and PCP data; 12 CMGs without PCP data; and 5 PCPs without complete MCO and CMG data. This left 10 MCOs, 19 CMGs, and 45 PCPs in the analysis.

“STDs are perceived by some plans as inexpensively treated ailments compared with investments in prevention and control.”

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 tive influence on delivery of some STD services. For example, if their MCO or CMG recommended the practice, providers were more likely to report that they annually screened adolescents for chlamydia and provided single-dose therapy for treating the condition.

Annual screening of young women for chlamydia was not recommended by any of the MCOs, yet 45 percent of the PCPs performed this test. Further analysis revealed that 59 percent of the CMGs affiliated with these PCPs had recommended this practice (data not shown). However, the CMG's recommendation seemed to be associated with PCPs' performance of this guideline: 77 percent of PCPs affiliated with groups that recommended annually screening young women reported this practice versus 28 percent who were affiliated with groups that did not recommend it. Another counterintuitive finding was the smaller proportion of PCPs who reported testing and treating their patients' sexual partners, regardless of expected reimbursement, in plans and groups that recommended it compared with the proportion in plans and groups that did not. Additional analysis did not reveal any plan or group characteristics that could have contributed to this finding. The most likely explanations are the legal liabilities in providing care to those not directly under a physician's care and the prohibition of such treatment by the health plan, state, or medical boards at the time of this study.

■ **Reasons for compliance or noncompliance.** We asked MCO and CMG respondents and PCPs why they did not recommend or comply with a particular guideline. Plan and group respondents cited the cost of routine screening as the reason for not recommending it. A few mentioned provider autonomy as a reason for not recommending single-dose therapy for chlamydia, and several mentioned medical liability as a reason for not recommending treatment of sex partners and the possible legal liabilities if their PCPs treated nonmembers. Some plan respondents also reported that they did not recommend STD guidelines because STD control was a low priority, because of the perception that it was inexpensive to treat STDs, the belief that the incidence of STDs was low among their patient populations, or their recent entry into the Medicaid market (which implies a lack of familiarity with the health problems of the Medicaid population or not being prepared to serve them).

PCPs, however, consistently cited financial constraints as barriers to following some guidelines. The exclusion of medications such as Azithromycin from the health plan or Medicaid formulary was cited as a reason for not using it to treat chlamydia. Providers also reported that the lack of payment for some procedures that were deemed unnecessary by MCOs and the lack of funds for universal testing were reasons for not screening sexually active adolescents annually.

■ **Impact of organizational and individual characteristics.** We also studied a

number of organizational and individual characteristics that may influence STD service delivery. We found that more PCPs working in clinics or hospitals or who were female reported screening sexually active adolescents than did those who were male or in private practice (Exhibit 4). Similarly, more physicians than nurse practitioners or physician assistants reported contacting the health department for partner notification.

PCPs with more than 50 percent Medicaid patients reported annual screening of adolescents and young women for chlamydia more often than did PCPs with less than 50 percent Medicaid patients. Similarly, PCPs who were in groups with more than 50 percent Medicaid patients screened teens and directly observed patients taking their single-dose chlamydia medication more often than did PCPs who were in groups with less than 50 percent Medicaid patients.

Discussion And Policy Implications

This preliminary study focused on Medicaid MCOs that enrolled populations at higher risk of contracting STDs. Despite the limitations of the samples, the findings raise concerns about whether MCOs as currently configured are effective vehicles for public health approaches to controlling STDs. The results also provide some direction regarding interventions to enhance clinical approaches to controlling STDs.

Overall, lack of organizational priority is a major barrier to providing STD care to Medicaid populations. STDs are perceived by some plans as inexpensively treated ailments compared with investments in prevention and control. The turnover in Medicaid eligibility and Medicaid enrollees makes it less likely that a plan will reap the benefits of prevention and early treatment in the short term. However, the costs of high STD rates and the consequences of prolonged illness are more likely to severely affect the public in the long term.

Alternatively, the common element among guidelines frequently practiced by PCPs appeared to be the ease of administration or a possible consensus within the medical profession rather than the presence of a recommendation from the plan or group. Practices such as presumptive treatment of chlamydia in the presence of gonorrhea may be influenced by cost concerns, since treatment may be less costly than testing. However, counseling practices may be influenced by the provider's training and comfort with discussion of STD practices.¹⁶

■ **Role for state policy.** Recommended STD practices targeted to Medicaid managed care patients can be promoted and improved through state policy. By 1999 most state managed care contracts in the seven states studied had STD-related content limited to services and benefits; only Tennessee's and Oklahoma's contracts had language that was specific to chlamydia and gonorrhea.¹⁷

State Medicaid programs can improve STD control and management by incorporating options such as developing and adopting explicit practice standards; providing adequate reimbursement for STD services such as routine screening of

EXHIBIT 4
Primary Care Providers' (PCPs') STD Management Practices, By Selected PCP, Contracted Medical Group (CMG), And Managed Care Organization (MCO) Characteristics

PCP characteristic	Use single-dose therapies for chlamydia	Screen sexually active adolescents annually for chlamydia	Screen women ages 20–24 annually for chlamydia	Direct observation of oral dosage for chlamydia or gonorrhea	Alert public health department to do partner notification	Test and treat partners regardless of membership or reimbursement
Gender						
Male	76%	35%	41%	46%	50%	71%
Female	77	64	50	60	70	59
Reimbursement method						
Capitated	78	57	45	56	65	52
FFS or both	62	38	31	50 ^a	67	77
Practice setting						
Clinic/hospital	77	63	60	60	60	69
Group, solo, other	72	42	26	46	68	53
PCP job title						
Medical doctor	77	53	47	54	70	65
Nurse practitioner, physician assistant, other	69	54	43	56 ^a	50	57
Size of Medicaid population						
Less than 50%	81	38	35	52	65	63
50% or more	71	75	65	58	59	65
CMG characteristic						
Size of Medicaid population						
Less than 50%	81	33	26	38	59	59
50% or more	67	88	76	83	71	67
Number of doctors in group						
Fewer than 10	91	40 ^a	36 ^a	80	55	67
10 or more	70	58	48	43	67	61
MCO characteristic						
Size of Medicaid population						
Less than 25%	75	45	42	44 ^a	58	33 ^a
More than 75%	75	56	47	58	66	73
Number of contracts with medical groups						
10 or fewer	80 ^a	20 ^a	20 ^a	75 ^a	80 ^a	40 ^a
More than 10	83	46	40	45	44	64

SOURCES: See Exhibit 1.

NOTES: MCO analysis in this exhibit excludes 11 MCOs without CMG and PCP data; CMG analysis excludes 12 CMGs without PCP data; and PCP analysis excludes 5 PCPs without complete MCO and CMG data. This left 10 MCOs, 19 CMGs, and 45 PCPs in the analysis. STD is sexually transmitted disease.

^a Cell size is less than 5—in other words, fewer than five responded.

adolescents, promoting single-dose therapy for chlamydia, and testing and treating nonplan partners; effectively promoting the use of recommended standards of STD care; and mandating standards of STD care in contractual agreements with

“Adequate STD services by Medicaid MCOs can be assured by including specific language in purchasing contracts with states.”

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Medicaid MCOs, including adequate financial incentives to implement recommended practices and penalties for failure to do so. Provision of adequate STD services by Medicaid MCOs can be assured by including specific language in purchasing contracts with states.¹⁸ It remains to be seen how the newly implemented Health Plan Employer Data and Information Set (HEDIS) performance measure of annual chlamydia screening of young women may encourage screening, but it is a step in the right direction and is likely to have some impact.¹⁹

■ **Caveats and starting points.** Because our findings are applicable to Medicaid managed care, no comparisons were possible with fee-for-service (FFS) Medicaid. Medicaid MCOs are likely to differ from FFS Medicaid in their delivery of STD care. The qualitative nature of this study precludes generalizing from our findings to all Medicaid MCOs. Similarly, self-reported physician practice may not truly reflect actual behavior, which is better measured through chart reviews. Nevertheless, these findings are a starting point for an important dialogue among managed care plans, state Medicaid programs, public health departments, advocacy groups, researchers, and beneficiaries. The ultimate goal of containing the STD epidemic and improving access of Medicaid managed care enrollees to appropriate STD services can be achieved only by raising awareness, increasing collaboration, and adopting and implementing effective policies.

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