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Applying Managed Care Techniques In Traditional Medicare

A compendium of strategies to bring the benefits of managed care to fee-for-service Medicare.

by Peter D. Fox

PROLOGUE: When auditors for the Department of Health and Human Services announced recently that the Medicare program had overpaid an estimated $23 billion in 1996, many observers were outraged, but few were surprised. The program’s financial and management woes, including the problem of fraudulent claims, were not a new concern. Congressional reformers were already looking for ways to cut $115 billion from the program’s projected costs over the next five years; doctors, hospitals, and managed care plans were already bracing themselves for reductions in Medicare payments; and the program’s administrators were already seeking to run a tighter ship despite the bureaucratic obstacles they face as a public agency.

One of the many questions ahead for the Medicare program is how to streamline its fee-for-service program while continuing to encourage enrollment in Medicare health maintenance organizations. Analysts expect that the traditional program will continue to represent the majority of the Medicare population. In this paper, Peter Fox, an independent managed care consultant based in Chevy Chase, Maryland, and former vice-president of The Lewin Group, suggests that the celebrated efficiencies of managed care are not beyond the reach of the traditional Medicare program. Fox was once a Health Care Financing Administration official himself, and his paper reflects his understanding of both the organizational barriers and the opportunities involved in adapting managed care techniques to the fee-for-service sector.
ABSTRACT: Medicare has lagged behind the private sector in its reliance on managed care, which, properly done, has the potential to restrain budget growth and enhance quality. This paper addresses how the Medicare fee-for-service program—traditional Medicare—might apply managed care techniques. It first discusses the institutional constraints Medicare faces in implementing managed care techniques and then presents options for applying these techniques. I propose elements of an overall strategy to incorporate managed care in the fee-for-service program.

The intent of managed care is to maximize the value of the health care dollar, not just to constrain costs. As such, improving quality and access to care is among its goals. Many interventions that enhance quality also lead to lower costs. Although managed care is commonly defined as entailing a relationship between a payer and a defined network of providers, such as through a health maintenance organization (HMO) or a preferred provider organization (PPO) or network, this paper is not restricted to network-based options. However, it does exclude from consideration measures whose primary focus is price per unit of service. Also excluded are the more fundamental reforms that are being debated such as transforming Medicare to a voucher, or defined contribution, program.

Two factors motivate this paper. The first is the persistent increase in Medicare expenditures combined with the fact that the federal government has had far greater success in controlling unit costs than in controlling utilization. Managed care offers the potential for reducing utilization, which could reduce the pressures for benefit or reimbursement reductions.

Second, despite the rapid growth in HMO enrollment on the part of Medicare beneficiaries, the vast majority will remain in the fee-for-service system for the foreseeable future. As of July 1996, 38.1 million beneficiaries were enrolled in Part A and/or Part B; in July 1997 only 4.8 million were enrolled in HMOs with Medicare risk contracts. A change from a defined benefit to a defined contribution program would, to be sure, result in most beneficiaries’ being in private plans that incorporate managed care principles. Although this proposal has many supporters, its enactment appears politically improbable in the next few years.

Institutional Constraints In Implementing Managed Care Techniques

The federal government faces institutional constraints in implementing managed care that need to be considered in assessing options. For example, consider a physician who has not committed fraud but who has a highly inefficient practice style, including pro-
viding services that many in the medical profession view as unneces-
sary and even potentially harmful to patients. A private health plan
might exclude such a physician from participation, whereas Medi-
care would have difficulty doing so. Other institutional constraints
include the following.

■ The size and dominance of the Medicare program. Medicare
accounts for more than one-third of the patient volume of many
providers, and in some cases (such as ophthalmologists, oncologists,
and many internists), more than half. In general, concentration of
purchasing power enhances the ability to influence or control
providers’ behavior. However, Medicare’s size combined with its
being a public program create limits. For example, punitive meas-
ures such as termination from participation can make it difficult for
a provider to earn a living, particularly as Medicaid and some private
payers are likely to follow suit. One result is the tendency of govern-
ment to limit its attention to extreme outliers, which reduces its
ability to influence practice norms.

■ Due process requirements. Society is reluctant to allow gov-
ernment agencies the level of discretion afforded private-sector pay-
ers in making judgments on policy and managerial matters. Medi-
care is subject to both requirements that characterize federal
agencies in general, such as those set forth in the Administrative
Practices Act, and those in the Medicare statute. These require-
ments can be cumbersome and delay decision making.

■ Procurement and personnel policies. Government agencies
face restrictions in procurement and hiring that the private sector
does not face; as a result the latter can operate more flexibly.

■ Government in the light of day. Many decisions by private
plans are judgmental and made privately. In contrast, government
agencies are required to justify their decisions in public forums. The
concern about outside criticism—by the press, Congress, and investi-
gative bodies such as the Office of Inspector General and the General
Accounting Office—is ever present. One consequence is inaction.

■ Slowness in decision-making processes. Government agen-
cies are often slow in making decisions because of their size and
organization. For example, the Health Care Financing Administra-
tion (HCFA) issuance of program regulations can take several years,
as can approval of demonstration applications. Although HCFA, or
some successor agency, could improve its current performance,
some of the slowness is inherent in the nature of government and the
levels of approval required. Juxtaposed against this are health plans
that are nimble in decision making—for example, changing pay-
ment mechanisms frequently and making adjustments to reflect the
circumstances of individual providers within a network.
Congressional limitations on flexibility. Congress is often loath to allow the executive branch latitude in decision making. Alternatively, when legislation is first enacted, latitude may exist that becomes constrained over time. Statutes, except for those that might be repealed altogether, tend to become longer and more prescriptive with the passage of time.

Accountability. HMOs and many other health plans have “denominator” populations and thus can be held accountable for the health of those populations. In theory, the same could be said for Medicare as a health plan. However, the number of enrollees (that is, all beneficiaries in the fee-for-service system) is so large that population-based performance measures, such as those that employers and other purchasers of health care may require of the HMOs with which they contract, have less potential to affect the delivery system.3

Options For Applying Managed Care Techniques

Here I discuss options for applying managed care techniques grouped under the headings of (1) data/claims analysis, (2) administrative controls on utilization, (3) prevention and case management, and (4) areawide expenditure targets. Many of the options have not been fully researched and are presented as concepts for further exploration. Some may warrant being tested using HCFA’s research and demonstration authority. Indeed, a number are already under consideration by HCFA or are extensions of what is under way.

Data/claims analysis. Data are key to understanding the delivery system. HCFA has a rich array of mostly claims-based data, and the data systems have improved over the years. They have proved valuable for research and policy analysis purposes, among others. This section explores whether they can be used more directly for ongoing care management decisions.

Comparing quality of care. Purchasers, including HCFA for HMOs with Medicare risk contracts, are increasingly requiring HMOs and other managed care entities to provide data on performance, although existing measures are limited in scope. The most common ones are those developed by the National Committee for Quality Assurance (NCQA), which accredits HMOs and other managed care plans. Similarly, outcomes or performance data could be published for individual providers for selected high-prevalence conditions. As with the requirements on Medicare risk contractors, these need to be valid but not perfect. Data can affect patient care in two ways. The first is by making objective comparisons available to the providers in question. The second is through public disclosure, which has the potential for inducing patients to seek out the higher-quality providers, who in turn compete for patient volume.
“Most physicians know little about how they compare with their peers, particularly in terms of practice styles.”

As illustration of the potential for data to affect medical practice, in 1989 New York State started disseminating hospital- and physician-specific data for coronary artery bypass graft (CABG) surgery. The result was an impressive 41 percent decline by 1992 in risk-adjusted mortality. Interestingly, providers changed their performance as a result of the comparisons being available; in contrast, patients did not change providers as a result of the comparative data, as would have been evidenced by shifts in market share.

Identifying underservice. HMOs with Medicare risk contracts commonly use their data systems to identify persons who need care but who apparently are not receiving it. These services are prevention oriented and can result in documented cost savings. For example, several studies have been performed in HMOs on the effectiveness of reminders to obtain influenza inoculations. Since this is a Medicare-covered service, the Medicare records could be scanned and communications sent to beneficiaries who may not have been immunized. Because of data lags, the communications might be sent in the few weeks prior to flu season to beneficiaries who were not inoculated during the previous year. Another example in which claims data might serve to identify underservice is for diabetics, for whom regular retinal and foot exams are important; failure to obtain these exams can result in expensive services being delivered subsequently.

Improving provider profiling. Recent advances in commercially offered provider-profiling systems have been impressive. These systems rely on flexible relational databases and have modules that can adjust utilization data to reflect relative patient mix or severity of illness. The major market for these vendors is managed care plans, particularly HMOs. Although principally oriented toward identifying physicians with expensive practice styles, the systems also can identify quality problems.

HCFA faces greater constraints than HMOs do in using profiling data. The numbers of providers involved is larger; most HMOs require that enrollees elect a primary care physician who serves as “gatekeeper,” thereby allowing the HMO to hold a single physician accountable for all services received by a given patient; HMOs have greater ability to discuss performance with individual physicians; and private health plans are not subject to the due process requirements that characterize government agencies, particularly one such as HCFA that is administering a national entitlement program.
Nonetheless, several forms of intervention might be considered, which vary in their feasibility and impact. First, the data could serve to educate physicians, using the HCFA-funded peer review organizations (PROs) or other structure. Most physicians know little about how they compare with their peers, particularly in terms of practice styles. To affect performance, data must be presented in a way that is clinically sensitive and user-friendly. An open question is the potential effectiveness of providing information that is not tied to payment. Such information might have considerably more impact if combined with areawide budget targets, as described below. Second, the data could be used to sanction physicians who have particularly expensive practice styles. These sanctions might include requiring such physicians to explain their practice styles to a local peer group; being subject to prior authorization requirements for certain services; and being excluded from Medicare altogether, a measure that has historically been limited to physicians who are guilty of fraud, and then only after a lengthy judicial process.

Conducting utilization studies. The large, and largely unexplainable, variations in Medicare spending, both in the aggregate and by type of service, are well known. Additional effort to analyze these variations can have value only if the analyses will lead to action. At the milder end, the data could be broadly disseminated in the hope that doing so will stimulate providers, particularly physicians, in high-cost/utilization areas to become more restrained in their practice styles. A more effective application of the data would be to target interventions. For example, prior authorization of selected high-cost services might be performed only in areas where use is high. Provider profiling, including the application of sanctions, also might be initiated in these areas. Finally, areawide targets for Medicare spending might be established that would relate provider payment levels to the achievement of the targets in high-cost areas. Each of these options is discussed elsewhere in this paper.

Developing PPO arrangements. PPOs for the commercial population achieve savings through provider discounts, utilization management, and provider selection, although the latter occurs more in theory than in practice. Enrollees face incentives to use network providers, typically in the form of differential cost sharing (copayments, deductibles, or coinsurance). HCFA could use practice profiles to identify efficient physicians and negotiate arrangements with those willing to accept rates below those of Medicare or those who volunteer to cooperate with selected utilization management requirements such as prior authorization of services. Beneficiaries would have incentives (such as reduced cost sharing) to use these providers. In practice, this might be difficult to implement, particu-
larly on a scale large enough to achieve meaningful savings.

**Administrative controls on utilization.** Prior authorization/concurrent review. Prior authorization of selected high-cost services has potential for achieving savings. Most private plans, including indemnity plans, now review necessity for inpatient admission and continued stay. They also review selected diagnostic and elective surgical procedures. In areas with particularly high utilization, Medicare could require that these services be subject to prior authorization. In addition, concurrent review might be appropriate for home health and skilled nursing facility (SNF) stays. One key to the success of such an approach is the conduct of data analyses that target selected geographic areas and services rather than those that are comprehensive and unfocused.

**Primary care physician gatekeepers.** Most HMOs require that enrollees select a primary care physician, who is responsible for delivering or authorizing all services, except those that are rendered out of area or are emergency in nature. Similarly, many state Medicaid programs require in their fee-for-service program that beneficiaries select a participating primary care physician who serves a gatekeeper function. This physician is not placed at risk but may receive a monthly case management fee. This approach permits tracking most services delivered to any given patient back to a single primary care physician and offers two advantages. The first is the achievement of savings, as the experience of state Medicaid programs has documented. Second, physicians with a geriatric focus have long sought payment for telephone calls to patients and for dealing with family members and local social services agencies. The case management fee compensates physicians for these activities.

If mandating that Medicare beneficiaries designate primary care physicians is not politically feasible, financial incentives in the form of reduced cost sharing or Medicare premiums might be offered to enrollees who agree voluntarily to obtain services through a primary care physician. One problem with reduced cost sharing, however, is that almost 90 percent of the elderly now face only minimal cost sharing because they have additional coverage, including Medicare supplemental policies (“Medigap”), retiree benefits, and Medicaid.

**Prevention and case management.** These two topics are viewed as linked. Prevention for elderly or disabled populations can occur across a continuum of health status levels or levels of functioning and can be categorized as follows: (1) primary prevention, directed at persons who are fundamentally well and for whom exercise, inoculations, diet, not smoking, and so forth are important; (2) secondary prevention, directed at persons with conditions that are largely asymptomatic such as hypertension or diabetes, for whom
“Medicare traditionally has operated as a financing rather than a health program.”

self-care classes, outreach programs, printed materials, and so forth can be helpful; and (3) tertiary prevention, directed at persons with known chronic conditions that entail functional deficits such as heart or pulmonary disease. Tertiary interventions are designed to prevent further deterioration. Case management can be viewed as a form of tertiary prevention.

The experience of HMOs with Medicare risk contracts with extensive elderly-oriented programs is particularly instructive with regard to prevention, although the Medicare fee-for-service program cannot replicate the full range of interventions that HMOs have adopted. Many HMOs believe that a key to financial success is the retardation of deterioration and the maintenance of function in order to reduce hospital use among enrollees with chronic illness. A full exposition of these efforts is beyond the scope of this paper; what is presented here is merely indicative of the interventions that might be considered.12

However, two shifts in thinking regarding how Medicare functions would be required. First, Medicare traditionally has operated as a financing rather than a health program, although recently it has made efforts to embed geriatric principles in its payment mechanisms. Second, the program generally operates independently of other federal programs. One option, which is explored later in this section, is grants to community agencies that fall outside of HCFA’s traditional purview but that could integrate with the Medicare program. The rationale for this is to avoid the budget exposure associated with expanding benefits through an open-ended fee-for-service payment mechanism.

Long-stay nursing home patients. For nonskilled-level (typically, long-stay) patients—that is, those for whom Medicare does not cover the daily room and board charges—Medicare coverage rules require physician visits upon admission to the facility, at least every thirty days for the first ninety days, and every sixty days thereafter. In practice, visits of greater frequency are often questioned by the fiscal intermediary. Indeed, it is often easier to transfer a resident to a hospital than it is to keep him or her in the nursing home. Doing so is also more lucrative, for the physician, the nursing home, and the hospital. Evidence also exists that many nursing home residents who are transferred back and forth between the nursing home and the hospital experience decreased quality of life and the exacerbation of other physical and mental conditions.13
The provision of additional services, whether by physicians or nurse practitioners, has the potential to reduce hospital admissions. HMOs have experienced large reductions in emergency room and hospital inpatient use as a result of enhanced primary care. Thus, HCFA should review its coverage and payment rules to assure adequate primary care to long-stay nursing home residents.

Self-care for elderly/disabled persons. Structured self-management and behavior change programs have been demonstrated to improve health outcomes and, presumably, reduce use of the health care system for a variety of conditions, including diabetes, heart disease, hypertension, and arthritis. A number of HMOs have found self-management programs to be cost-effective. The challenge, however, is to implement them in a fee-for-service environment.

As with some of the other programs, an open-ended payment mechanism is not recommended. However, nationwide informational programs might be undertaken along with grants, perhaps on a pilot basis initially, to local community agencies such as Area Agencies on Aging, public health departments, or provider groups. One example of a successful program mounted in a fee-for-service environment is that of Medicaid in Maryland for diabetics. A 40–50 percent reduction in inpatient care and emergency department use has been achieved through a combination of structured outpatient education programs, which are viewed as the cornerstone of the effort; case management; and primary care providers’ attending a five-hour course in diabetes management (for which they receive continuing medical education credits).

Also, “nurse line” or “advice nurse” programs could be piloted, through which enrollees can telephone a central toll-free number and obtain information on self-care as well as whether medical care is needed and, if so, how immediate the need is. In some cases, the conversation results in a referral to case management. Significant savings have been claimed as a result of these programs.

Local agencies to conduct secondary and tertiary prevention. The Medicare program has little experience with joint endeavors with local agencies such as local health departments or the federally funded Area Agencies on Aging, many of which have health care programs for the elderly. For example, many such agencies perform case management, but it is not integrated with Medicare nor is it oriented toward reducing use of medical, particularly inpatient, services. Grants might be made to such agencies (or existing funding reoriented) for programs to help elderly persons who are disabled or have functional limitations. Prospective grantees would have to present detailed plans to be eligible for funding. A block grant with limited strings attached is not intended; rather, the grantees should become
contract agents of HCFA. Since many of the functions would be new, modest developmental funds might be desirable.

Case management is one possible function. Research to date on the cost impact of case management for the Medicare population has been less than encouraging. The so-called channeling demonstrations of case management conducted in the 1980s failed to reduce costs for a frail elderly population, even with the availability of additional funds to purchase community-based services. Carefully controlled research has not been conducted in the HMO setting, although many plans have case management programs, which they justify based on an evaluation methodology that entails comparing actual costs with an estimate of what costs would have been in the absence of case management. Two frequently encountered problems in the HMO setting, which would be exacerbated if the locus of case management were a community agency, are (1) coordination between the case manager and the primary care physician, and (2) patients’ refusing case management as an intrusion into their lives.

Nonetheless, one should ask whether the negative findings to date reflect the inherent shortcomings of case management or, instead, its implementation. In contrast to the Medicare experience, the Maryland Medicaid program instituted case management in twelve large medical centers and reports savings of 24 percent. To be cost-effective, case management should carefully target its population and limit the resources that are invested. Also, many HMOs use case management as the gateway to off-policy benefits. For example, a case manager may be authorized to pay for simple home repairs or additions, such as fixing steps or adding grab rails in bathrooms, to prevent falls. A limited amount of money might be available for such purposes.

The local grantee agency also could conduct disease management programs for a limited number of conditions. Education and regular follow-up (such as to check problems with medication and weight) have been found to reduce hospital readmissions for persons with congestive heart failure. Other functions that the local community agency could perform, all of which are performed in some HMOs, include (1) conducting home assessments, for example, to spot problems that can generate falls; (2) developing support or self-help groups, for example, for diabetics, cancer patients, bereaved persons, and caretakers of Medicare beneficiaries who are frail or disabled; (3) developing or arranging for exercise programs that are geared to an elderly or disabled population; and (4) mounting volunteer programs, such as friendly visiting and telephoning.

As an illustration of such a program, the Group Health Cooperative of Puget Sound and PacifiCare have teamed up with a senior
citizen center in Washington State to offer supervised health promotion and chronic illness self-management interventions to chronically ill seniors. The intervention, which entails a randomized, controlled trial, includes meetings with geriatric nurse practitioners to develop an individually tailored health promotion plan, medication reviews, classes, support groups, and volunteer mentors.

Preliminary, as yet unpublished, findings reveal significant reductions in hospitalizations, higher levels of physical activity, and reductions in the use of psychoactive medications. The intervention group also experienced fewer disability days than the control group and less decline in “activities of daily living” (ADL) functioning, although no difference was observed in functional status as measured by the so-called SF-36.

**Areawide expenditure targets.** This proposal is perhaps the most far-reaching in this paper. It entails establishing areawide expenditure targets to which physician (and possibly other provider) payment would be tied, to create incentives to constrain utilization. The physician payment reform legislation enacted as part of the Omnibus Budget Reconciliation Act of 1989 included provisions for creating national expenditure targets for physician services, known as the Medicare volume performance standards (MVPS). Performance nationally relative to the targets results in physician payment levels’ being adjusted upward or downward.

Areawide expenditure targets are intended to correct two shortcomings of the current law. First, there is no vehicle or intent under current law for physicians to come together nationally to influence performance other than, perhaps, through a general education campaign. Thus, the MVPS serves as a budget control device, not as a mechanism to constrain utilization. Second, the target is based on expenditures for physician services only, accounting for a subset of Medicare Part B expenses, and does not, for example, allow physicians to be rewarded financially for constraining use of Part A services.

The proposal would entail, starting perhaps in high-expenditure areas, establishing targets for all Medicare expenses within a given geographic area and rewarding or penalizing physicians for how expenditures compare with the targets within that area, which would be of such a size that physicians could review the care delivered by their peers—for example, a metropolitan area. The intent is both to constrain overall spending and to reduce the existing wide geographic variations. The approach would entail a fundamental change in incentives within the fee-for-service system and would work best in conjunction with some of the other measures discussed above such as prior authorization for selected services and the timely availability of severity-adjusted data. Demonstrations might be con-
ducted initially that would provide positive incentives only, thus allowing doctors to share in savings but not penalizing them if the savings are not realized.

**Conclusion**

This paper seeks to serve as a source of ideas and not to present a specific set of recommendations, particularly as the options described require refinement before they can be implemented. Although presented as individual options, a successful managed care strategy requires an integrated approach. For example, one cannot determine the data analyses that merit being undertaken without knowing their end use. As another example, a program to precertify use of selected high-cost services is more likely to be effective in conjunction with the proposal for areawide expenditure targets, which entails changes in physician payment incentives.

Another determinant of program success is targeting. The geographic variations in spending patterns are well known, and greater efforts at program cost savings are more warranted in high- than in low-expenditure areas. Furthermore, the use rates of specific procedures correlate only imperfectly with aggregate spending. Thus, successful intervention requires consideration of local circumstances.

Indeed, the wide variations are likely to gain attention as a public policy issue as more beneficiaries enroll in HMOs with Medicare risk contracts. These HMOs are able to offer broader benefits at lower premiums in high- than in low-expenditure areas, leading to benefit variations that reflect accidents of geography. Although cost management interventions that differ geographically may be regarded as violating an underlying premise of the Medicare Act as a program that is uniform nationally, that uniformity is already being challenged by the growth in Medicare risk enrollment and the resulting variations in the benefit package. Recognition of the need for different approaches to cost management, which will largely be invisible to beneficiaries, seems far less problematic.

Yet another determinant of success in managed care is the manner in which a program is implemented. Even the terminology often has different meanings in different situations. For example, most HMOs have case management programs, but they are dissimilar from one another. Finally, successful managed care plans are characterized by flexibility in decision making, including the ability to make changes over time. Although government agencies are by their nature constrained from acting as quickly as private plans can act, decision making can be accelerated.

Some of the more promising elements of managed care that might be considered are as follows: (1) Identify high-cost areas and proce-
dures. In those areas, institute programs of provider profiling, physician incentives, and services precertification. (2) Implement areawide targets in high-cost areas. (3) Initiate demonstrations of grants to local agencies to institute prevention programs, particularly tertiary prevention programs, and case management, with a limited budget being available for off-policy benefits. (4) Bring more of a geriatric focus to the Medicare program such as by changing the coverage rules for nursing home visits for long-stay patients and experimenting with advice nurse programs.

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NOTES

1. The distinction between price and utilization is at times blurred in that some policy changes affect both price and utilization. A good example is the Medicare prospective payment system (PPS), which reimburses hospitals principally on a per case basis, thereby encouraging hospitals to constrain the use of ancillary services and lengths-of-stay.

2. Health Care Financing Administration, 1996 Data Compendium (Baltimore: HCFA, 1997), 46; and HCFA, Office of Managed Care, Medicare Managed Care Contract Report (issued monthly).

3. Examples of population-based measures are reflected in the Health Plan Employer Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance (NCQA).


6. See, for example, N.A. Hanchak et al., “The Effectiveness of an Influenza Vaccination Program in an HMO Setting,” American Journal of Managed Care 2, no. 6 (1996): 661–666.

7. One shortcoming is that beneficiaries may receive inoculations through community organizations that do not submit claims to Medicare.

8. See, for example, Dartmouth Medical School, Center for Evaluative Clinical Services, The Dartmouth Atlas of Health Care, Part IV (American Hospital Association, 1996), 59–79.

9. Wide variability exists in the relationship between Medicare payments and what providers will accept from managed care plans. For example, in some market areas many specialists accept payments that are 20 percent or more below Medicare fee levels, whereas in most markets Medicare payment levels
are viewed as low. This approach would be designed, in part, to achieve savings in markets where Medicare pays more than private health plans do.

10. R.E. Hurley, D.A. Freund, and J.E. Paul, Managed Care in Medicaid: Lessons for Policy and Program Design (Ann Arbor, Mich.: Health Administration Press, 1993). One caveat regarding the interpretation of research results is that most of the Medicaid experience relates to the Aid to Families with Dependent Children (AFDC), not the Supplemental Security Income (SSI) (that is, aged and disabled) population.


12. For examples of a variety of interventions used by HMOs geared to a chronically ill population, see A.M. Kramer, P.D. Fox, and N. Morgenstern, “Geriatric Care Approaches in Health Maintenance Organizations,” Journal of the American Geriatric Society 40, no. 10 (1992): 1055–1067; P.D. Fox and T. Fama, eds., Managed Care and Chronic Illness: Challenges and Opportunities (Gaithersburg, Md.: Aspen Publishers, 1996); and P.D. Fox and T. Fama, “Managed Care and the Elderly: Performance and Potential,” Generations (Summer 1996): 31–36. HMOs vary widely in the extent to which they have mounted programs that are focused specifically on elderly or disabled populations.


15. See, for example, J.B. Burl, A. Bonner, and M. Rao, “Demonstration of the Cost-Effectiveness of a Nurse Practitioner/Physician Team in Long-Term Care Facilities,” HMO Practice (December 1994): 157–161. David Reuben at the University of California, Los Angeles (UCLA), is completing a study of three HMOs with enhanced primary care for long-stay nursing home residents; preliminary findings are encouraging.

16. E.H. Wagner, B.T. Austin, and M. Von Korff, “Improving Outcomes in Chronic Illness,” in Managed Care and Chronic Illness.

17. Center for Health Program Development and Management, University of Maryland, Baltimore County, State of Maryland Diabetes Program (DCP), An Independent Evaluation of the Waiver Granted to the Maryland Department of Health and Mental Hygiene under Sections 1915(b)(1) and (3) of the Social Security Act (Baltimore: UMBC, 13 September 1995).

18. Center for Health Program Development and Management, University of Maryland, Baltimore County, Maryland Medicaid High Cost User Initiative: Case Management and Cost Savings Annual Report, CY 1995 (Baltimore: UMBC, March 1996). The savings reported are based on estimates of the costs that would have occurred absent the intervention rather than on the experience of a control group. Notwithstanding limitations in the methodology, the order of magnitude of the savings is impressive.


20. There has always been a lack of uniformity because of (1) variations in the availability of medical resources, and (2) differences among fiscal intermediaries in the interpretation of coverage and other rules. However, these differences are smaller than those caused by geographic variations in HMO premiums and benefits, which now exceed $1,000 per beneficiary per year.