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# COORDINATED CARE AND PUBLIC PROGRAMS

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by Gail R. Wilensky and Louis F. Rossiter

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**Prologue:** *When the federal government's major health care financing agency was created at the advent of Medicare, it was patterned after the operations of its private counterpart—Blue Cross and Blue Shield. It became an agency that mainly paid bills based on the claims of providers. Over the years, the Health Care Financing Administration (HCFA) has sought to transform itself from strictly paying claims to being a more aggressive overseer of the health financing transactions between its beneficiaries and providers of service. About halfway through its twenty-six-year stewardship (essentially, during the period when Medicare and Medicaid merged to become HCFA), the federal government concluded that taxpayers would be well served if more elderly and poor people enrolled in health maintenance organizations (HMOs), the earliest managed care model. In this paper, Gail Wilensky and Louis Rossiter report on the current status of HCFA's efforts to promote managed care. The federal government has come a long way in its pursuits, but it has a long way to go before managed care (or, as the authors prefer to call it, "coordinated care") becomes an acceptable option to many beneficiaries. Wilensky, with a doctorate in economics from the University of Michigan, has been administrator of HCFA for almost two years. A nationally recognized health services researcher, Wilensky directed the Center for Health Affairs (CHA) at Project HOPE from 1983 to 1989. The multidisciplinary CHA conducts research for government agencies and private-sector organizations. Rossiter, who holds a doctorate in economics from the University of North Carolina, is a professor of economics at the Medical College of Virginia campus of Virginia Commonwealth University. Rossiter recently returned to academe after spending nearly two years at HCFA working directly with Wilensky on a wide range of subjects.*

If we wanted to set about creating a health care system with economic incentives for cost excess, it would be the current American system of health care. Fee-for-service medicine encourages the use of services of marginal value. Health insurance shields patients from the real costs of care. Fear of malpractice motivates doctors to do excessive testing and prescribing. The public's recognition of the current incentives to drive costs ever upward is key to solving the access problem faced by the thirty-three million Americans without health insurance. Consensus is growing that we must address the cost problem to make headway on the access problem.

The reasons for a trade-off between costs and access are clear. The money needed to address access to care will not be available unless credible methods can be found to contain costs. The impact of new costs on growing health care budgets at all levels of government will always stand as an impediment to change. To remove the impediment, we must think boldly about incentives that secure better value in health care. Merely decreeing lower costs addresses symptoms, not causes. True reform of health care will require a change in Americans' willingness to tolerate the higher costs of expanded coverage. True reform will require individuals to pay more if they want maximum coverage and unlimited choice. True reform will require a restructuring of incentives to reward providers not for doing more, but for doing what is best.

Discussions of health policy reform need to include reducing administrative costs, making the cost of health insurance more affordable for small businesses, encouraging the use of cost-effective procedures through outcomes research, improving primary health care, and changing tax policies regarding health insurance. A central focus of health care reform, however, needs to be managed or coordinated health care plans.

The role for coordinated care now and in the future is not only to provide a potential for cost control, but also to expand financial access to care and improve quality through coordination of care. The evidence is growing that coordinated care is helping to reach these goals.

In the private sector, the drive toward delivery system reform is well under way, witnessed by the rapid growth in managed care. Only a few lonely observers call for a return to unbridled fee-for-service plans. In the public sector, the intent is the same. Years of enthusiastic support for coordinated care plans by Washington policymakers have resulted in the HMO Act, Medicare risk-based contracts, and prepaid coordinated care in the federal/state Medicaid program. We see strong signs of an enduring presence for coordinated care in Medicare and Medicaid.

The purpose of this essay is to describe the current coordinated care activities in the public sector and indicate future directions. We depict

the approach that the Health Care Financing Administration (HCFA) is mapping to enable and encourage individuals and families to determine the kind of health care they will receive.

A number of forces are at work to make the future very favorable for coordinated care throughout the U.S. health care system. The positive outlook is no less evident in the public sector. Coordinated care can better ensure access and coordinate the care of people covered by public programs, who tend to have more complex needs. The coordination of care should be the goal, not managed care for its own sake. That is why, at HCFA, we have started to use the term *coordinated care*, rather than *managed care*. Coordinated care better expresses the idea that well-organized care improves quality and puts taxpayers' dollars to better use.

Properly structured to allow consumer choice, coordinated care can provide strong incentives for accessible, high-quality, patient-oriented care, while encouraging cost-conscious decision making. The desire to attract and retain enrollment focuses the plan on quality assurance and enrollee satisfaction that would be difficult to match in a publicly administered, monolithic plan.

Individual choice of plans is a critical reason to rely on coordinated care when reforming public health care programs. Choice of physicians is also important for those who enroll in a coordinated care plan. Some people want both. Our approach to coordinated care must strike an appropriate balance between these freedoms. If appropriate care can be delivered more efficiently by a network of physicians and hospitals working together, those who agree to use that network should pay less than those who want to go to any provider at any time. The incentives should be structured to gauge individual willingness to pay, avoiding subsidies whereby some pay for others' excesses.

Coordinated care is growing in Medicare and Medicaid. But we must ask whether we need wait for the most structured form of coordinated care—the health maintenance organization (HMO)—to dominate public programs, or whether other related forms should be encouraged as well. In time, the related forms should evolve into more integrated, risk-bearing forms, similar to HMOs, if HMOs continue to be the most successful form of coordinated care in the market.

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### Recent Trends And Innovations

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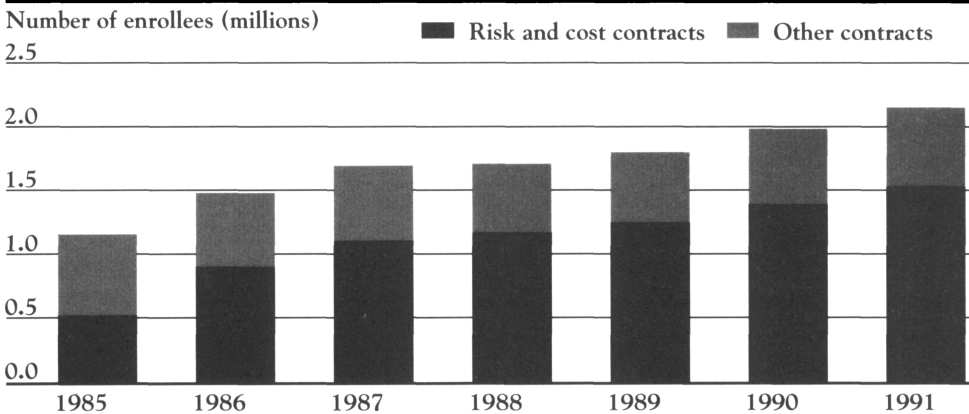
More than five million Americans are now enrolled in Medicare or Medicaid coordinated care programs. There were 2.1 million enrolled in Medicare HMO risk or cost contracts and 2.6 million enrolled in Medicaid HMO, prepaid health plan (PHP) contracts, or primary care case

management programs as of fall 1991.

**Medicare.** HMO risk contracts are the largest and fastest-growing portion of coordinated care activities under Medicare (Exhibit 1). There are 1.35 million people enrolled under the HMO risk program. HMOs accept a predetermined capitated amount for enrolled Medicare beneficiaries in return for organizing and providing all of their Medicare-covered benefits. Beneficiaries voluntarily enroll for this option. As part of the enrollment process, they sign a form, indicating that they understand that in order for their nonemergency medical care to be covered, it must be received through the plan. The plans provide the benefits associated with Medigap coverage—at most, they require only small copayments at each physician visit. In addition, their benefits include preventive services and may include coverage for prescribed medicines. A contractual agreement with HCFA is required, and the HMOs agree to accept full risk. They are free to bundle payments for services and pay providers as they wish. The HMOs process their own claims for provider payments.

Medicare HMO cost contracts also have a large and growing enrollment, but growth is slow. There are 753,000 people enrolled under an HMO cost or other contract. HMOs in this category are paid lump sums for the service and administrative costs associated with Medicare beneficiaries in the plan. While enrollees are expected to use the HMO providers, they are free to seek care outside of the plan, and Medicare will pay on a fee-for-service basis. When beneficiaries opt out of the plan, they may pay Medicare deductibles and coinsurance. Similar to risk contracts, HMO cost contractors also voluntarily provide the benefits associated with Medigap coverage, including preventive services. The HMO must

**Exhibit 1**  
**Total Medicare Enrollment In Coordinated Care Contracts, 1985–1991**



Source: HCFA Office of Coordinated Care.

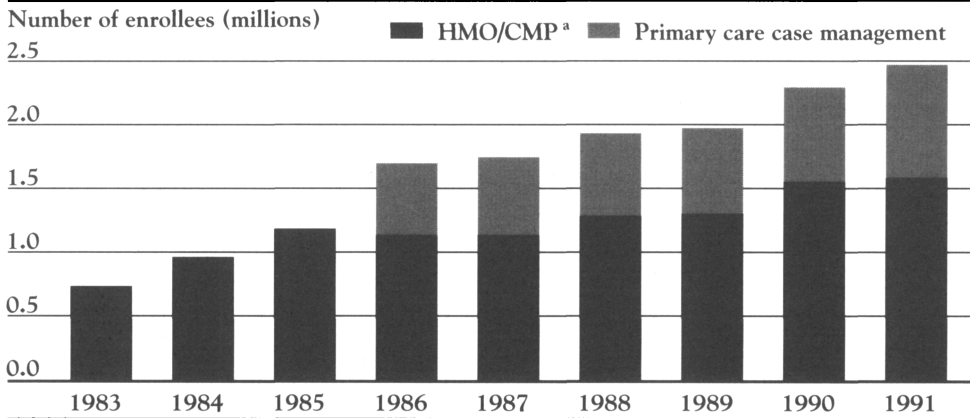
have a contract with HCFA but bears no risk for covered services. It processes its own claims for the care provided within its network of providers; HCFA processes all other claims.

**Medicaid.** Medicaid HMOs and prepaid health plans have been serving the Medicaid population for nearly twenty-five years.<sup>1</sup> More than 1.6 million people are enrolled under an HMO or prepaid health plan risk contract with the states (Exhibit 2). HMOs and prepaid health plans accept predetermined capitated amounts for enrolled Medicaid eligibles in return for organizing and providing all services. HMOs provide a comprehensive set of Medicaid-covered services. Prepaid health plans generally provide a subset of services, for example, acute inpatient care, ambulatory physician services, and prescribed medicines, but not long-term care. Medicaid eligibles enrolled in either type of plan must use the HMO network or pay for care entirely out of pocket. Thus, there are strong reasons for enrollees to remain within the coordinated care network.

Primary care case management programs, a more recent coordinated care innovation in Medicaid, were launched in the wake of the Omnibus Budget Reconciliation Act (OBRA) of 1985. Before 1986, enrollment was small, but today it is growing rapidly. More than one million Medicaid eligibles are expected to be enrolled in primary care case management programs by the end of 1991. They represent the fastest-growing portion of coordinated care in public programs.

Primary care case management programs work by contracting with individual primary care providers, primary care organizations, HMOs, or

**Exhibit 2**  
**Total Medicaid Enrollment In Coordinated Care Contracts, 1983–1991**



Source: HCFA Office of Coordinated Care.  
<sup>a</sup>Health maintenance organization/competitive medical plan.

prepaid health plans to be fully responsible for providing primary care services and overseeing referrals. The primary care case management program may pay the case manager via fee for service or capitation. The contract with the case manager can be directly with the state or through an intermediary. It can be structured with a range of utilization review requirements such as preauthorization from the case manager for specialty care or hospital admission.

Primary care case management programs may be voluntary or mandatory for Medicaid eligibles. In Colorado, Iowa, Florida, and Michigan, an important innovation is in place: mandatory enrollment in the primary care case management network is required, unless the individual opts out to enroll in an HMO. The approach provides a dual option for recipients, but the default is primary care case management.

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### Continuum Of Coordinated Care Choices In Medicare

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At the core of mapping out a coordinated care strategy for Medicare and Medicaid is an assumption that various options can be structured that offer reasonable trade-offs between costs and the type of health care delivery system one chooses (Exhibit 3). Coordinated care poses trade-offs for both individuals and policymakers, involving program costs, out-of-pocket costs, managed care network features, legally enforceable contracts to guarantee access, and the ability to self-refer, among other things. If people are allowed to choose among these trade-offs, a reasonable balance can be struck between competing needs. Government does not wish to impose the same requirements on people with varying needs or preferences.

**HMOs versus fee-for-service medicine.** In Medicare, there are two existing extremes: traditional, “à la carte,” fee-for-service medicine and HMOs. Fee-for-service medicine has incentives for expenditure excess

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**Exhibit 3**  
**Coordinated Care Options For Medicare Beneficiaries**

	Fee for service	Medicare Select	Point-of-service	HMO risk contract
Enrollment required		•		•
Beneficiary cost incentives		•	•	•
Contract with HCFA required			•	•
Bundled payments			•	•
Coordinated inpatient/outpatient care			•	•
Claims processing by plan				•
Risk				•

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Source: HCFA Office of Coordinated Care.

and possible poor quality through inappropriate or unnecessary care. Beneficiaries, however, in principle, can obtain care at any participating provider, usually after a deductible has been met. HMOs have incentives for cost cutting, and quality may be jeopardized through skimping on or denying care. Yet, with effective monitoring of HMOs, beneficiaries can be assured of a structured organization that coordinates their care and ensures quality.

In many geographic areas, Medicare beneficiaries dissatisfied with fee-for-service medicine are free to join an HMO, and those dissatisfied with their HMO are free to join another HMO or to return to the fee-for-service system. HMOs have the benefit of requiring little or no paperwork compared with fee-for-service medicine. Experience shows that Medicare HMOs offer more Medigap benefits, including preventive services, for a lower premium than that of traditional Medigap policies.<sup>2</sup> By using structured quality assurance systems and utilization review programs, some Medicare HMOs have been able to reduce hospitalization and increase the use of primary care.<sup>3</sup> HCFA studies have shown that beneficiary satisfaction is very high in HMOs and equal to that found in Medicare as a whole.<sup>4</sup> The quality of care in Medicare HMOs is at least equal to that of fee-for-service medicine and often superior in the area of primary care.<sup>5</sup> HCFA-supported studies have identified a full range of services more likely to be available to Medicare HMO enrollees than to fee-for-service enrollees. Other HCFA-supported studies have found the care in HMOs for high-cost, resource-intensive conditions was very similar to that in fee-for-service medicine.<sup>6</sup> The Medicare HMOs that do well financially are those with good coordinated care programs that hold down costs and are located in geographic areas where the capitation amount is very high.<sup>7</sup>

**HMO group-only contracts.** A relatively modest change in the current HMO risk program has been proposed by the Bush administration to provide new opportunities for employers to coordinate benefits with Medicare. The proposed HMO/competitive medical plan (CMP) group-only contract would permit employers to establish an HMO/CMP and enroll only their retirees who are Medicare beneficiaries. An open enrollment would not be required for any beneficiary in such a plan. Medicare would pay its normal HMO payment to the group-only HMO, and the employer would contribute any further required premium for combined Medicare and supplementary coverage. A new Financial Accounting Standards Board (FASB) ruling will require employers to show health benefits promised to retirees as liabilities on their balance sheets in 1993.<sup>8</sup> Employers thus are looking to reduce retirees' health care costs even more than they have in the past. Savings are possible if Medicare and supple-

mental insurance can be combined and coordinated, as the group-only option proposes to do.

**HMO cost contracts.** Medicare HMO cost contracts are essentially the same as risk contracts from the beneficiary's point of view. HMOs that are not ready to bear the risk of Medicare enrollment and need more time to develop their experience with the elderly use the HMO cost contract. While Medicare cost contracts have been in existence for many years, little is known about their cost-effectiveness. It is widely assumed that they are cost-effective because beneficiaries are treated within the coordinated care network. But the payment incentives to coordinate the care are not strong, and beneficiaries can be referred or self-refer to the regular Medicare program at any time. HCFA is currently conducting a thorough review of cost contracts and anticipates moving away from them.

Yet another variation of the cost contract is the health care prepayment plan. Such contracts are for Medicare Part B services only, allow plans to conduct screening at enrollment, and face virtually none of the consumer protection requirements that Medicare risk-contract HMOs face. HCFA is supporting legislation to eliminate this option, a relic from another era, with its plan-specific, cost-based reimbursement for only physician services and some supplier services, and its near absence of incentives for cost-conscious behavior.

**Medicare Select.** Adjacent to unfettered fee-for-service medicine and traditional Medigap insurance is a new form of coordinated care called Medicare Select. Beneficiaries who join a Medicare Select plan buy what is essentially traditional fee-for-service Medigap coverage, except that the coverage is limited to providers and suppliers within a managed care network defined by the Medicare Select insurer. Thus, full Medicare benefits plus payment of Medicare's deductibles and coinsurance are provided if the beneficiary stays within the managed care network. If the beneficiary goes outside the network, full Medicare coverage is provided, but the Medigap insurer may not pay Medicare's deductibles and coinsurance. Medicare Select was recently authorized by the 1990 OBRA legislation. Section 4358(c) of OBRA authorized fifteen states to begin to allow such policies to be sold in early 1992.

**Point-of-service plans.** The continuum of coordinated care options in Medicare is nearly complete today, with several forms of HMOs and preferred provider organizations now permitted by law. But the current options—Medicare Select and HMO cost and risk contracts—are all enrollment models. Beneficiaries must sign up for the existing alternatives to move away from "à la carte" fee for service and often pay a premium to do so. To bring coordinated care to virtually all Medicare beneficiaries, HCFA is working on a nonenrollment model, called a



point-of-service option.

The point-of-service option would establish new Medicare contracting entities with the responsibility to develop a comprehensive network of Medicare preferred providers in an area. Preferred providers would be selected based on quality assurance systems, demonstrated outcomes of care, and negotiated prices (combining Parts A and B for high-volume and high-cost procedures). These providers would be expected to manage each case so that hospitals and physicians work together in providing services. The point-of-service contractors would develop and distribute materials in their area that would promote the use of the managed care network by beneficiaries. Where point-of-service is available, beneficiaries could choose a Medicare point-of-service provider or opt to receive Medicare benefits as usual. If beneficiaries selected a point-of-service provider, they would receive a partial rebate on their Part B premium.

There are two key aspects of the point-of-service option. The first is that, similar to the HMO option, the point-of-service contractor would designate a list of providers with effective quality assurance, including evidence of good treatment outcomes, from which the beneficiary could choose. The point-of-service contractor would have access to the HCFA data files to profile providers in an area; also, the contractor could use new guidelines being developed by the Agency for Health Care Policy and Research to compare provider performance and could choose providers with the best adherence to the guidelines. An important departure from "Medicare as usual" is that Medicare would be helping beneficiaries through the medical maze more than it has ever done before.

The second key aspect of the point-of-service option is that the bundling of Part A and Part B services will result in a substantial reduction in paperwork. About 60 percent of Medicare's costs are for the top 100 high-volume, high-cost procedures. The most costly procedure in aggregate is coronary artery bypass graft (CABG), with a total annual cost of about \$3 billion. A typical CABG episode involves about eight to twelve Medicare claims, with the attendant paperwork for beneficiaries, providers, and HCFA. When the point-of-service contractor bundles services and negotiates a single global fee, one Medicare claim, paid by a special contractor, results per case. If all CABG procedures had been paid under a bundled arrangement this year, HCFA's claims processing for CABG would have fallen by 87–91 percent, from 1.3 million to about 150,000 transactions.

The bundling of Part A and Part B payments will have a more profound impact on the quality and the nature of the care delivered. By combining Part A and Part B payments, hospitals and physicians will work under the same payment incentives when caring for patients. Under the traditional

Medicare structure, hospitals and physicians work under different, sometimes conflicting, economic incentives. United under a single set of incentives, they can form a team to develop the best quality care delivered in the most efficient way.

The details of the point-of-service option are still being developed. The idea is included in the president's budget proposals for fiscal year 1992. It would be a budget-neutral program under the new budget rules that require a pay-as-you-go approach to legislative proposals.

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### Continuum Of Coordinated Care Choices In Medicaid

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The coordinated care mechanisms for Medicaid have evolved into somewhat different forms from those of Medicare (Exhibit 4). This may strike one as odd, because of the often overlapping populations the two programs cover. However, there are good reasons for the different forms.

First, Medicaid prohibits patient cost sharing for categorically needy recipients. Cost sharing is used by managed care organizations to shape the incentives to use coordinated care. A preferred provider organization, for example, will require coinsurance only if the patient goes outside the managed care network. Because patient cost sharing is prohibited, these incentives are not available to managed care entities in Medicaid.

A second reason is the presence of Medicare supplemental coverage, which is not applicable to Medicaid in designing coordinated care programs. Medicaid usually pays in full for a comprehensive set of benefits, thus obviating the need for supplemental coverage. In contrast, Medicare covers basic medical and hospital services, leaving many other services uncovered. Consequently, about 70 percent of Medicare beneficiaries have some supplemental coverage. Encouraging managed care through the private supplemental insurance market thus is a Medicare option but

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**Exhibit 4**  
**Coordinated Care Options For Medicaid Recipients**

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	Fee for service	Primary care case management		HMOs and prepaid health plans <sup>a</sup>
		Fee for service	Capitated	
Enrollment required	●	●	●	●
Access guaranteed by contract	●	●	●	●
Waiver from HCFA required	●	●	●	
Bundled payments			●	●
Coordinated inpatient/outpatient care				●
Claims processing by plan				●
Risk				●

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Source: HCFA Office of Coordinated Care.

<sup>a</sup> Waiver from HCFA required if traditional Medicaid not available as recipient option.

not an option for Medicaid.

**HMOs versus fee-for-service medicine.** As in Medicare, the Medicaid continuum for coordinated care begins at one extreme with “à la carte,” fee-for-service medicine; it ends at the other extreme with HMOs. As before, either extreme has incentives for potentially poor-quality care. HMOs offer the benefit, however, of always involving an organizational structure to oversee quality and help coordinate the care, as well as cost awareness when care is inappropriate or unnecessary. HMOs are also contractually obligated to provide care and make provisions for accessible care. In fee-for-service Medicaid, patients are on their own to find providers who will treat them, raising questions of adequate access to care.

The most important reason for coordinated care in Medicaid is enhanced quality and accountability. The impact on costs has been modest in practice. Nevertheless, Medicaid managed care holds promise for arresting cost increases, especially compared with fee-for-service medicine. Studies find savings from zero to 5.8 percent resulting from Medicaid managed care.<sup>9</sup>

By using structured quality assurance systems and utilization review programs, Medicaid HMOs and prepaid health plans have reduced the use of emergency room and outpatient department visits and increased the use of primary care services, especially for children.<sup>10</sup> To hold down costs and improve quality, many HMOs use primary care case management. A primary care case manager can keep enrollees from self-referring to specialty care or receiving intermittent care at emergency rooms or hospital outpatient departments—costly behaviors that occur when people have no ongoing relationship with a physician.<sup>11</sup> Reductions in the use of emergency room services are the most pervasive and substantial utilization effect of primary care case management.<sup>12</sup> With the exception of one study, which only involved one well-managed HMO, most studies have found that effects on specialty care and hospitalization are not as obvious.<sup>13</sup> Most importantly, however, primary care case management adds accountability to a program with little reputation for it.

**Prepaid health plans.** Prepaid health plans are next on the continuum of coordinated care for Medicaid. The rules for prepaid health plans are less stringent than those for HMOs because prepaid health plan contracts are not for a comprehensive set of services. States can enter into prepaid health plan contracts without HCFA central office approval. As for HMOs, they must allow disenrollment without cause. Most states, however, seek prepaid health plan contracts along with what is known as a 1915(b) freedom-of-choice waiver.

This waiver gives the state the option of limiting the number of participating plans and allowing Medicaid enrollees to choose only from

among those plans. Freedom-of-choice waivers are an increasingly popular way for states to require Medicaid recipients to use plans that emphasize primary care and preventive services. Nearly always, a primary care case manager is the centerpiece of patient management for a prepaid health plan; thus, the states see these contracts as providing a framework for organizing a continuing relationship with a primary care physician.

**Primary care case management.** The next level on the continuum, the primary care case management option requires a 1915(b) freedom-of-choice waiver. Primary care case management is a further step away from payment for a comprehensive set of services. With primary care case management, however, a primary care physician is paid to manage all Medicaid services, while the services continue to be paid under usual fee-for-service procedures. Primary care case managers' responsibilities range from preauthorization of all Medicaid services to simply seeing the patient on a regular basis. There are numerous contractual arrangements between the state Medicaid programs and the primary care provider.<sup>14</sup>

Aside from the payment mechanism for the case manager, the key to these programs is that Medicaid eligibles are required to select a primary care case manager and go through that case manager for services. States may make selection of a case manager by Medicaid recipients merely one of a range of options, or they may require it. A number of states assign a case manager after an eligible has been given an opportunity to and for any number of reasons does not select a case manager.<sup>15</sup>

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### Coordinated Care Policy Initiatives

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HCFA is sponsoring a number of important policy initiatives in coordinated care for both Medicare and Medicaid. In Medicare, there have been well-publicized accounts of changes in the peer review organization (PRO) review of HMOs and development of an external review effort in the private sector to replace PRO review in Medicare. In Medicaid, the new HCFA Medicaid Bureau is undertaking an initiative to develop uniform standards for quality assurance across states and to upgrade state standards. Also in Medicaid, a new streamlined waiver request process is being developed to lessen the burden for states in developing managed care programs. Coordinated care technical advisory panels for both Medicare and Medicaid are being considered. In a recent general solicitation, HCFA's Office of Research and Demonstrations highlighted projects that would study coordinated care delivery systems and payment methods in both programs.

Last year, at the request of the secretary for health and human services, HCFA established new demonstrations for applying coordinated care

principles to treat substance abuse in pregnant women. Up to five awards to states were made in the fall of 1991. Bundled payment demonstrations for CABG and cataract surgery are well under way. The CABG demonstration, which combines Part A and Part B payments into one global fee, is going very well in four sites. At least two cities are slated to be selected soon for bundled payments for cataract surgery. OBRA 1990 authorized up to \$40 million for states to extend Medicaid coverage to certain low-income families not now eligible for Medicaid using Medicaid buy-out and buy-in arrangements. Under the experiments, states can make a partial premium payment from Medicaid for private insurance coverage (buy-out), or employers or individuals can pay a premium for Medicaid coverage (buy-in). Coordinated care approaches are attractive to this new demonstration because they would allow states to establish a predetermined capitation payment that Medicaid and an employer or individual could share in paying.

**Adequacy of payment.** Despite all of these important initiatives to sustain and enhance coordinated care in public programs, perhaps the most critical and vexing policy issue is the payment system for coordinated care plans. Public programs will probably always be in competition with private-sector plans for providers. This is as it should be, to avoid a two-tiered system of care. But public competition in the private arena will always make the adequacy of the payment rate an issue. It is already an issue today in fee-for-service programs, especially Medicaid, as providers allege that public programs are skimpy payers and try to shift costs. Moreover, the payment level is an important determinant of enrollment growth in coordinated care plans. So if public policy is to support voluntary growth in managed care enrollment, it must have an adequate payment system. Achieving parity with private plans costs money that governments do not have. Thus, the search is on for appropriate, adequate, and stable payment rates in Medicare and Medicaid, especially for capitated programs.

To squarely address the payment issue in Medicare, the Bush administration has proposed that HMOs would receive an outlier payment above the 95 percent payment that they currently receive of the adjusted average per capita cost (AAPCC) in the fee-for-service sector of Medicare. The current formula does not adjust for health status of the beneficiary beyond age and institutional status, nor are there any adjustments if a disproportionate number of high-cost Medicare beneficiaries are enrolled in an HMO in any year.

Thus, this proposal would change the current payment policy by creating an outlier pool to pay HMOs for a portion of the costs of very high cost cases. The outlier pool would be funded from the Medicare Trust

Funds by setting aside 2 percent more of the AAPCC above the current 95 percent limit. Payments would be made to plans from the outlier pool for a portion of costs above some threshold (for example, Medicare costs above \$50,000). HMOs would be responsible for identifying those cases that exceed the threshold and reporting them to a Medicare fiscal agent that would process the outlier payments.

The outlier pool idea amounts to a form of health status adjustment for HMOs to protect them against the risk of not enrolling the average mix of beneficiaries in an area. Half of Medicare benefit costs are spent on beneficiaries who are in their last two years of life. As much as 10.2 percent of all Medicare spending is for less than 0.5 percent of beneficiaries with costs above \$50,000 per year. The outlier pool would afford protection against very high cost cases that make the Medicare population so risky for many plans.

The approach to improving the payment system in Medicaid for coordinated care plans is different from Medicare because the states are responsible for determining how managed care plans are paid. States have varying experience with managed care contracting. To share that experience, we are issuing standard methodologies that states can use in determining fee-for-service upper payment limits and capitation payments for HMOs and prepaid health plans. The Medicaid Bureau also is contracting with an actuarial firm to determine different ways of setting Medicaid HMO capitation payments. An emphasis will be placed on methodologies for states that no longer have a fee-for-service base to use in setting HMO rates because of the large number of Medicaid participants in managed care plans in certain geographic areas. In this way, states are not “reinventing the wheel” each time they enter the coordinated care market.

Another important part of that actuarial review will be to examine the claim that capitation payments, based on fee-for-service Medicaid, are inappropriately low because they do not account for lower levels of access and fragmented care received by patients in fee-for-service Medicaid. If an adjustment factor were included in the capitation, to account for the better coordinated access to care provided in an HMO, the payment rate might be higher than the fee-for-service rate.

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## Conclusions

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Incentives in the American health care system push costs in only one direction: up. This does nothing to ameliorate problems with access to care. We need bold initiatives to contain costs, and boldness is not likely to be found in the regulation of fee-for-service medicine. At the same

time, public programs cannot rely on the purest form of coordinated care—HMOs—to somehow overtake the system and achieve instant universal enrollment. While HMO enrollment should be given priority, not all Americans will choose HMOs. Thus, we must develop related forms that have the potential to evolve into prepaid group practice offering the best coordinated care in the marketplace.

A continuum of choices is in place in Medicare and Medicaid. Innovations and enhancements are being developed to make alternatives to traditional fee-for-service medicine as attractive as possible. Perhaps the most vexing issue for coordinated care in public programs is the payment issue. If public programs are to compete for resources in the private market and see that all Americans have access to a health insurance plan that meets their needs, we must offer payments that are adequate, accurate, and stable. Toward this end, HCFA is working on a number of fronts to give the people served by our programs choices that serve them best.

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#### NOTES

1. Another coordinated care form in Medicaid is the health-insuring organization. Often operated by local political authorities, these organizations arrange for comprehensive services on a risk basis. Unless health-insuring organizations have been operating since before 1985 and are grandfathered under the section of the law governing HMOs (section 1903(m)(2)(a)), they operate like HMOs and are considered HMOs for this discussion.
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