

# Massachusetts Medicaid and the Community Medical Alliance: A New Approach to Contracting and Care Delivery for Medicaid-Eligible Populations with AIDS and Severe Physical Disability

Robert J. Master, MD

## **Abstract**

**This paper discusses the origins and experiences of the Community Medical Alliance (CMA), a Boston-based clinical care system that contracts with the Massachusetts Medicaid program on a fully capitated basis to pay for and deliver a comprehensive set of benefits to individuals with advanced AIDS and individuals with severe disability. Since 1992, the program has enrolled 818 individuals with either severe disability, AIDS, mental retardation, or general SSI-qualifying disability. Under a fee-for-service system, these two groups had received fragmented care. The capitated CMA program emphasizes patient education and self-management strategies, social support and mental health services, and a team approach to healthcare delivery that has reoriented care to primary care physicians, homes, and communities.**

*(Am J Man Care 1998;4:SP90-SP98)*

Medicaid programs are aggressively moving to enroll people with disabilities in prepaid health plans at the very time when the strategies of prepaid contracting and care delivery are beginning to evolve from the "one size fits all" approach widely prevalent for relatively healthy employed and welfare-eligible populations. A transformed version of prepaid financing has enormous potential to promote new care delivery designs. These new designs can substantially improve the quality of care for people with serious disability or chronic illness, compared with those found in the prevailing fee-for-service system. However, unless many

of the prevailing managed care strategies that are being steadily catalogued anecdotally (eg, in newspaper articles, legislative hearings, op-ed cartoons, and the stories of bitter clinicians and patients) are changed, the dangers for people with disabilities are readily apparent.

In this paper the Community Medical Alliance (CMA) strategies that have evolved under health status-adjusted capitation payments for populations with AIDS or severe disabilities are examined and contrasted to the prevailing iterations of managed care. Also described are the advantages associated with new payment approaches to prepaid contracting for care of severely ill or disabled persons—approaches based on clinical assessment of health status. Last, CMA's service use, cost, and clinical outcome experience over 5 years in care of populations with AIDS or severe disability are described.

## DESCRIPTION OF CMA

CMA, a subsidiary of Neighborhood Health Plan, is a Boston-based clinical care system contracting with the Massachusetts Medicaid program on a fully capitated basis to pay for and deliver a comprehensive set of benefits to two specific population groups with exceedingly high costs and fragmented, uncoordinated care: individuals with advanced AIDS and individuals with severe disability. These subpopulations require the most medically complex care of any the Medicaid populations in greater Boston. In 1992, Massachusetts Medicaid pioneered health status-adjusted premiums on an experimental basis in its contract with CMA.

Care for enrollees is provided through five primary care practices in three hospital systems. Each enrollee has a primary care physician teamed with a trained nurse-practitioner. These care teams have complete

From Community Medical Alliance, Boston, MA.  
Address correspondence to Robert J. Master, MD, Community Medical Alliance, 31 St. James Ave, Suite 950, Boston, MA 02116.

authority to order services and direct the contracted network of medical specialty, home health, personal care, private-duty nursing, home infusion, day health, foster care, mental health, substance abuse, hospital, hospice, and skilled nursing facility providers.

To develop the premiums for high-cost enrollees eligible for CMA, Massachusetts Medicaid performed a claims analysis in 1991, identifying 110 Medicaid-covered individuals with AIDS living in greater Boston who had at least one AIDS-defining opportunistic infection or malignancy in the previous year. A subsequent, more in-depth claims detail then determined that the fee-for-service (FFS) average for the Medicaid-covered benefits contracted to CMA for this population (ie, all Medicaid benefits excluding oral pharmacy) was nearly \$4,800 per individual per month. This rate was approved subsequently by the Health Care Financing Administration as an upper payment limit for Medicaid patients with advanced AIDS in the greater Boston area. It became the basis of a \$4,478 per month premium payment to CMA for the care of individuals with advanced AIDS who voluntarily enrolled.

Similarly, a claims detail was performed on the 1990-1991 FFS experience of 192 severely disabled adults in greater Boston who were eligible for the Massachusetts Medicaid PCA benefit (individuals with permanent extensive disability such that personal assistance for all activities of daily living is required on a permanent basis). The results led to a monthly premium payment of \$1,997 for the care of this population beginning in 1992.

With these health status-adjusted payments, it soon became imperative to redesign the delivery system so that it was attuned to the populations. CMA's experience indicated that to create improved delivery systems for these populations, the clinical roles, the care relationships, and the organization of care that had evolved under decades of FFS reimbursement had to be transformed. In addition, the prevailing contract, management, incentive, and benefit design strategies of managed care had to be abandoned because they were found to be incompatible with the care needs and clinical imperatives of the enrolled population. Instead, CMA posited that the use of prepaid financing, rather than the FFS payment system, could foster innovative care.

---

#### ADVANTAGES OF HEALTH STATUS-ADJUSTED PREMIUMS

It is axiomatic that a small percentage of any population group accounts for the lion's share of expendi-

tures from year to year. The vast majority of employed or welfare-eligible populations have only intermittent healthcare needs; as a result, there is very little predictability from year to year as to which subgroup will be the high-cost users. In contrast, many readily identifiable subpopulations of Medicaid's population who are eligible for Supplemental Security Income (SSI) (eg, those with wheelchair dependency, chronic persistent mental illness, mental retardation, sickle cell disease, or AIDS) have continuous healthcare needs over time; these needs and their associated costs are substantially more predictable from year to year.<sup>1</sup> The "insurance principal" that uses an average premium payment without health status adjustment would suffice for the general population. However, it is an inadequate approach for Medicaid's disabled populations because the high-cost users are identifiable in these populations, making the costs predictable from year to year.

With an average premium, plans that in theory offer specialized care management programs attractive to large numbers of individuals with high-cost disabilities would experience financial losses and strong incentives to discontinue such care management. The solution, health status-adjusted payments, is moving from development to application. Specific approaches such as the ambulatory care groups, the diagnostic care groups, and the disability payment system all are available today for state Medicaid programs to vary capitation payments so that they roughly match the healthcare needs of plans' enrollees.<sup>1,2</sup> With a range of health status-adjusted rates reflecting an approximate matching of cost to healthcare needs, plans would have the financial incentive to innovate in care management rather than to use risk avoidance strategies.

#### Greater Opportunities for Reducing Secondary Complications

Compared with relatively healthy individuals, individuals with serious disability or chronic illness have low thresholds for a predictable array of secondary complications. These complications drive much of their medical care use and costs and cause much physical and personal disruption. The typically lower thresholds for complications make systematic early-intervention strategies especially valuable. In the CMA care system, urinary tract infections, respiratory infections, and severe skin ulcers account for more than 70% of all hospital admissions for individuals who have spinal cord injury or the more severe forms of muscular dystrophy, cerebral palsy, multiple sclerosis, or spina bifida; all these complications are ame-

nable to simple, proven preventive or early-intervention strategies.<sup>3</sup> Because most individuals with these disabling conditions are often acutely sensitive to the onset of these secondary complications, experience has shown that strategies that lower barriers to communication are crucial to effective early interventions. Thus, when an individual with a spinal cord injury, for example, senses recurrence of a urinary tract infection, a prepaid care system that funds systematic, rapid, in-home, personalized responses is arguably more effective than a system that provides care through distant, often-intimidating hospital specialty clinics that are difficult to access and may only be available a few times a week.

Prevention of such secondary complications also is facilitated when a care system uses its resources to define and implement planwide standards of care. For example, the use of annual screening renal ultrasound examinations and the implementation of policies that promote the rapid deployment of specialized beds, mattresses, or home nursing services have been shown to be effective strategies for reducing the incidence of hospitalizations for serious episodes of urosepsis or skin breakdown in a variety of severely disabled populations. These strategies, however, are incompatible with standard utilization management determinations of medical necessity or service requirements. By analogy, there also are proven strategies for other chronic conditions including asthma, congestive heart failure, cystic fibrosis, and severe persistent mental illness. These strategies remain very underdeveloped in the FFS system and can only be applied systematically with prepaid financing.

### **Promotion of Education and Self-Management Strategies**

As noted above, the widespread systematic application of self-management strategies as a way to reduce secondary complications remains very underdeveloped in the FFS system today. Diabetes care via empowered, educated individuals with the illness virtually stands alone as an example of how a complex, chronic illness can be managed and the incidence of disabling secondary complications reduced without constant professional interventions. Because most other chronic illnesses lend themselves to similarly effective self-management strategies, systematic population-based investment in these strategies has enormous potential to reduce a wide range of secondary complications and the attendant health service costs. In the CMA system, enrollees in collaboration with nurse-practitioners self-manage episodes of urinary infections, respiratory infections,

dysreflexia, and a variety of AIDS-related complications.

### **Focus on Social Support and Mental Health Services**

For individuals with serious disability or chronic illness, inadequate attention to social and mental health needs quickly translates into increased medical service and hospital costs. In 1995, acute and chronic hospital expenditures per member per month doubled for CMA enrollees with advanced AIDS because the percentage of the enrollee cohort who lived alone or who bordered on homelessness increased from 10% to nearly 50%. Similarly in 1995, in CMA's program for severe physical disability, primary care nurse-practitioners estimated that about one third of hospital admissions occurred because of social reasons or ineffective mental health interventions. Thus, the terms "not medically necessary" or "noncovered services" mean little when they refer to the unmet needs for support, housing, or mental health of a vulnerable population with very low thresholds for the inevitable secondary medical complications.

CMA has found that effective prepaid care for these populations does not limit, exclude, or segregate such services, but rather uses the flexibility of capitation to invest in redesigned network services that can be an essential part of the solution to finding alternatives to hospital use and expenditures. Examples of this network redesign include specialized foster care for individuals with advanced AIDS who have cognitive impairments; rapid-response crisis intervention services in lieu of the emergency room or "pink paper" (ie, involuntary commitment for in-patient psychiatric evaluation) for individuals with acute, threatening mental health problems; enhanced personal care attendant services for individuals with physical disabilities who are experiencing medical or emotional complicating issues; day health centers for a range of individuals with cognitive impairments; and drug detoxification services on demand. Few of these targeted interventions are possible in the FFS system. Fewer still occur through "command and control" managed care overlays or new financial risk arrangements with primary care physicians that are designed to discourage "referrals."

### **Benefit Design With Consumer Input**

As a general rule, the managed care industry relies on "expert" professionals to design the standards, protocols, and software to support utilization management and benefit design policies that proscribe what and how many services are appropriate. However, the

CMA experience has been that the most effective and least costly approaches to care often are best designed by those with intimate knowledge of a specific disability, as well as by those who have personally experienced the deficiencies of prevailing FFS and managed care systems. For example, CMA's primary care model, which uses nurse-practitioners and extensive home visiting, was designed collaboratively with disabled individuals under the auspices of Boston's Center for Independent Living. This model was designed in response to the deficiencies of distant, impersonal care and the disempowerment experienced in specialty clinics and emergency rooms.

Too often, those closest to the problem and those with the best knowledge of workable, cost-effective, care-appropriate solutions have been excluded from the design process. When such consumer or advocacy input is solicited, it may be viewed as a "diversion" to be managed or manipulated. Regarding prepaid care for the disabled, the CMA experience is that such design input is central to the "product."

#### REALIZING PRINCIPLES OF MANAGED CARE AT CMA

The CMA experience (approximately 1500 enrollee years, mostly with severely disabled and advanced AIDS patients) is admittedly limited with respect to the populations served and geography. Nonetheless, CMA's experiences with cost and care illustrate tangibly how this alternative strategy for prepaid care can be put into practice. The principles used by CMA may be applicable to larger, more heterogeneous populations with substantial needs and high costs.

#### CMA Principles and Program Elements

The principles and program elements underlying CMA's prepaid system can be summarized as follows:

- Empowerment and support of the primary care role;
- Use of a team approach to primary care with the ability to make clinical decisions and allocate resources at any place and at any time;
- Use of flexible benefits with focus on social, mental health, or support service needs as alternatives to hospital or institutional care;
- Elimination of command and control overlays;
- Avoidance of payment arrangements that potentially can foster mistrust between patients and their primary care clinicians;

- Emphasis on continuity and personalized management of acute inpatient care; and
- Use of specially designed service networks.

#### *Empowerment and Support of the Primary Care Role.*

In the CMA system, primary care physicians are selected because of their ability to care for disabled populations with medically complex problems and their willingness to work as part of a team to manage all of a patient's clinical issues in all settings. Primary care physicians have complete authority to admit patients to the hospital, to refer patients to specialists,

*CMA's model ... was designed in response to the deficiencies of distant, impersonal care and the disempowerment experienced in specialty clinics and emergency rooms.*

or otherwise to order or allocate resources from virtually the entire contracted network without having to ask for permission or risk financial penalty or loss of income. Primary care physicians are supported by a team approach to care (described below) and a management system that promotes the ordering of disparate home and community services (eg, home intravenous therapy, respiratory therapy, private-duty nursing, transportation, day treatment, enhanced personal care services) with one call or fax.

*Use of a Team Approach to Primary Care With the Ability to Make Clinical Decisions and Allocate Resources at Any Place and at Any Time.* Most severely disabled individuals have multidisciplinary care needs. They also have low thresholds for secondary complications that require a rapid evaluation and therapeutic response at all times and in all locations. Therefore, a team approach to care is essential. For disabled populations whose disability is extremely complex medically, such as those with AIDS or the variety of conditions that cause severe physical disability, sophisticated nurse-practitioners with prescriptive

authority and broad latitude in ordering appropriate diagnostic and therapeutic interventions have demonstrated extraordinary effectiveness in this team role.<sup>47</sup> For populations whose problems are less medically complex and whose needs are predominantly in the areas of coordination, surveillance, and education, the team role can be assumed by nurses or perhaps other healthcare professionals, although this role has yet to be as clearly defined or rigorously evaluated.

In CMA's severe physical disability and AIDS programs, the nurse-practitioners have caseloads of 60 and 35, respectively. They provide ongoing primary care, the first response to new problems, instruction in self-care, care management when alternatives to hospitalization are used, and coordination of medical and nonmedical services. They also assume first call on nights and weekends and maintain primary responsibility for the implementation of screening and secondary illness prevention protocols.

*Use of Flexible Benefits With Focus on Social, Mental Health, or Support Services Needs as Alternatives to Hospital or Institutional Care.* CMA benefits include features that are rarely found in standard plans, but that have proven to be essential for effective alternatives to hospital care. Such unique benefits include (1) expanded home support with personal care attendants for episodes of illness, breakdown of family support, care and protection, or continuous surveillance of a socially unstable home situation; (2) multidisciplinary mental health home crisis intervention 24 hours a day and 7 days a week, as an alternative to "pink paper" or the use of the emergency room for evaluation; (3) care and protection low-intensity beds (for respite or supportive care) as an alternative to admission to a psychiatric hospital; and (4) specialized foster care in the case of unsafe home situations as an alternative to the hospital for patients who are actually or potentially homeless.

*Elimination of Command and Control Overlays.* Primary care physicians and nurse-practitioners confront a complex array of problems in their efforts to care for Medicaid SSI-eligible individuals. It is an enormously difficult job for which standard utilization management protocols have little relevance. When these managed care protocols are applied, they only serve to make a difficult job more difficult. It has been the CMA experience that despite the ready availability of alternative services, when a specialist, emergency room, or hospital is needed, *it is needed!* At no time should a primary care clinician confront obstacles in accessing these needed services.

*Avoidance of Payment Arrangements That Potentially Can Foster Mistrust Between Patients and Their Primary*

*Care Clinicians.* Trust is the essential ingredient in a positive physician-patient relationship, no matter what the context. At no time is trust more crucial than when medical care and access to needed services are lifelong ongoing critical priorities, as they are for individuals with serious disabilities or complex, chronic illness. There simply is no place for financial arrangements that in perception or reality threaten the bonds of trust.

In the CMA system, primary care physicians are paid on a monthly capitation basis and specialists are reimbursed on a FFS basis. There are no financial penalties for specialty, emergency room, or hospital referrals. For primary care physicians the capitation payment covers the following services:

- Ambulatory care as needed;
- Telephone consultation with nurse-practitioners, specialists, or patients;
- Team conferences;
- Availability 24 hours a day, 7 days a week; and
- Hospital inpatient care management.

*Emphasis on Continuity and Personalized Management of Acute Inpatient Care.* Since its inception, CMA always has required that primary care physicians manage all aspects of acute hospital inpatient care as the "physician of record" for all enrollees. Despite this authority, the inability of the primary care physician to be continually present, coupled with the sheer complexity and multiple priorities of large teaching hospitals, often led to situations in which care plans were unintentionally subverted, lengths of stay extended, and quality compromised. In response to these problems, two new enhancements were initiated in hospitals with sufficient volume in 1996. The first was the geographical aggregation of CMA enrollees on one floor to promote personalization of care, team building between inpatient staff and the outpatient care team, and the more effective transmission of the home- and community-based philosophy of care. The second was addition of a "nurse partner" to the primary care attending physician. This nurse partner maintains a presence on the floor during the week to promote efficient implementation of care plans, to provide patient reassurance and support, and to promote care plans that enable alternatives to hospitalization.

*Use of Specially Designed Service Network.* The selective contracting for service networks is not determined by price competition or hospital affiliation but by what works for primary care physicians and disabled enrollees. Ancillary service and physician specialty networks are built on the basis of existing

relationships with the primary care physicians and on the basis of services that the enrollees, their families, or their advocates identify as particularly excellent or needed. Thus, the networks do not always look "clean" from a traditional managed care viewpoint. Primary care physicians employed by large, vertically integrated hospital systems may well be able to refer to specialists, agencies, or vendors outside that system.

dence of a worsening case mix over time. In the severe physical disability program, enrollees have a mix of spinal cord injury, cerebral palsy, and degenerative neurologic illnesses as the basis for their disability. Over time the case mix of the disability group also worsened, as the percentages of the more medically complex and expensive subgroups with spinal cord injury and degenerative neurologic illness increased. The characteristics of these enrollee groups are summarized in Tables 1 and 2.

### PROGRAM EXPERIENCE

Since 1992, CMA has voluntarily enrolled 311 individuals with severe disability, 403 individuals with AIDS, and 104 individuals with mental retardation or general SSI-qualifying disability. Currently there are 208 enrollees in the severe physical disability program, 187 individuals in the AIDS care program, and 94 individuals in the program for general disabilities. CMA has its longest experience with the severe physical disability program and the advanced AIDS program, for which CMA has received health status-adjusted capitation payments since 1992. The experience with these programs has been described elsewhere and is updated in this report.<sup>7</sup>

The clinical criteria for enrollment in the severe disability and advanced AIDS programs (as well as eligibility for the 1996-1997 adjusted capitation rates of \$1,681 and \$4,476, respectively) were functional quadriplegia from any cause for the disability program and Centers for Disease Control and Prevention-defined AIDS with one or more documented AIDS-defining opportunistic infections or malignancies for the AIDS program. In return for these premium payments, CMA assumed unlimited responsibility for the entire array of Massachusetts Medicaid benefits with the exceptions of oral pharmacy, taxi, and dental benefits.

Individuals with far-advanced illness enrolled in the AIDS care program, and there has been evi-

In the severe physical disability program, clinical decision making shifted dramatically from specialists

### SERVICE USE AND COSTS

**Table 1.** Characteristics of CMA Enrollees, April 1, 1992–December 31, 1993

<b>AIDS Program (CDC-Defined AIDS with a Documented Infection or Malignancy)</b>	
■	113 enrollees
■	18.2% of greater Boston's Medicaid-eligible recipients with AIDS
■	56% in the risk group for intravenous drug use
■	Median CD4 cell count per cubic millimeter at enrollment = 61
■	Annual mortality rate = 50.4%
<b>Disability Program (Permanent Triplegia or Quadriplegia With Requirements for Personal Care Attendant Services, or Equivalent, to Maintain Independent Living)</b>	
■	119 enrollees
■	51% of greater Boston's Medicaid-eligible adult recipients with severe disabilities
■	51% with severe, stable neurologic illness (eg, cerebral palsy)
■	28% with cervical spinal cord injury
■	21% with severe, degenerative neurologic illness (eg, muscular dystrophy)
■	10% of the above patients were ventilator dependent

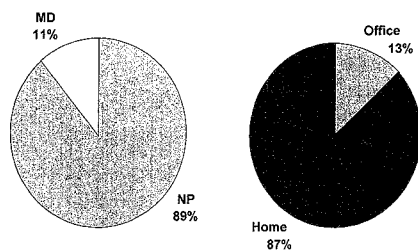
CDC = Centers for Disease Control and Prevention; CMA = Community Medical Alliance

**Table 2.** CMA AIDS Care Program Case-Mix Analysis, January 1, 1995–June 30, 1995

Characteristic	No. or Percent
Number of enrollees	112
Median CD4 cell count/cubic millimeter	31
Risk group for intravenous drug use	85%
Active MH/SA treatment	74%
Lives alone	27%
Supported housing	22%
Intermittently homeless	8%

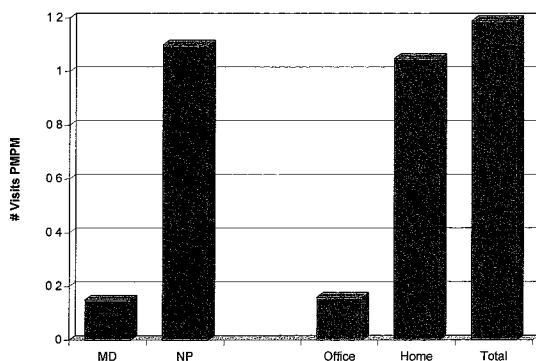
CMA = Community Medical Alliance; MH/SA = mental health/substance abuse.

**Figure 1.** Distribution of Primary Care Visits for CMA Members With Severe Physical Disabilities: 1994-1995



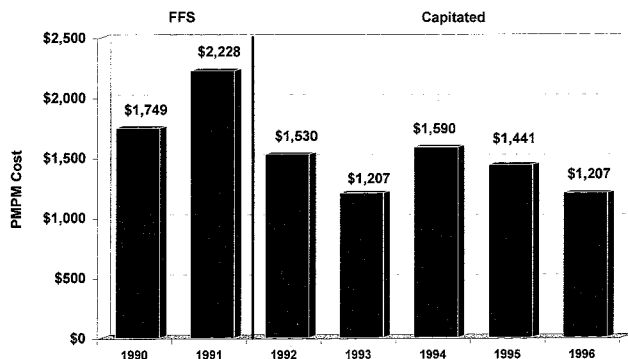
CMA = Community Medical Alliance; NP = nurse-practitioner

**Figure 2.** Average Number of Visits PMPM for CMA Members With Severe Physical Disabilities: 1994-1995



CMA = Community Medical Alliance; NP = nurse-practitioner; PMPM = per member per month

**Figure 3.** Total PMPM Costs for CMA Members With Severe Physical Disabilities (Medicaid Only): 1990-1991 (FFS) and 1992-1996 (Capitated)



CMA = Community Medical Alliance; FFS = fee for service; PMPM = per member per month.

and primary care physicians to nurse-practitioners. The vast majority of medical encounters were with nurse-practitioners in the home setting. The distribution and visit rates (per enrollee per month) are summarized in Figures 1 and 2. In the AIDS care program, the shift to nurse-practitioners and the home was substantial (approximately 40% of medical encounters), but not as dramatic as in the severe physical disability program.

Both programs have overall service use costs well under the capitation rates, although the accuracy of the advanced AIDS capitation rate was and remains questionable. Figure 3 summarizes the overall expenditures for severely physically disabled enrollees from 1992 to 1996 compared with the FFS cost average for this population from 1990 to 1991. These cost reductions were achieved through a greatly reduced use of the hospital compared with the FFS experience (Figure 4), with a considerable percentage of the capitation payments going to fund home health, durable medical equipment, primary care, and mental health services as alternatives to hospital care (Figure 5). Of note, medical specialty care expenditures have remained at less than \$30 per member per month (20% of primary care expenditures) and at less than 3% of the cost of the overall medical service.

In the AIDS care program, the overall cost experience was more erratic. Considerable increases were seen in 1995 compared with the prior and subsequent periods. These increases correlated with a caseload that had a greatly increased prevalence of inadequate or absent social supports or housing. The overall cost experience of the AIDS care program is summarized in Figure 6, with the distributions of costs in the 1994-1996 period summarized in Figure 7.

### SATISFACTION AND QUALITY

As previously reported, hospitalization rates for enrollees with AIDS or severe physical disabilities who had *Pneumocystis pneumonia* or pressure sores, respectively, were substantially lower than those found in the same populations previously cared for in FFS arrangements.<sup>3,7,8</sup> In 1996, with intensive home monitoring by nurse-practitioners to promote adherence,

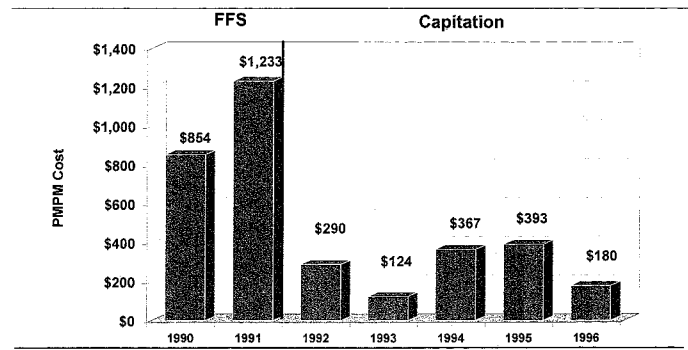
more than 40% of enrollees with advanced AIDS were able to adhere to rigorous multidrug protease inhibitor antiretroviral therapy for substantial lengths of time. As a consequence, the annual mortality rate declined in 1997 from 60 deaths per 100 enrollee years to 12 deaths per 100 enrollee years; hospital admissions and hospital days declined from 1.4 admissions and 14 days per enrollee per year in 1995 to 0.5 admissions and 5 days per enrollee per year in 1997. In addition, a variety of external reviews (National Committee for Quality Assurance-focused reviews and Medicaid semiannual reviews) as well as ongoing surveys documented a high degree of compliance with defined processes of care; enrollee satisfaction has been found to be consistently high and the voluntary disenrollment rate very low (1%). Because CMA enrollees have conditions that are extremely medically complex and medical specialist use has been exceeding low, surveys specifically designed to assess enrollee satisfaction with access to specialty services and mental health services have been used. These surveys have found enrollee satisfaction to be consistently high.

**SUMMARY**

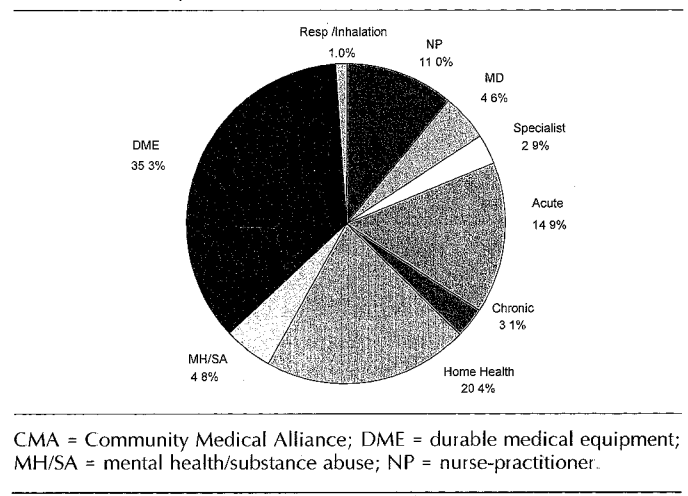
The CMA care system has transferred care from hospitals and specialists to primary care physicians, homes, and communities. In doing so, CMA contained overall costs and maintained a high degree of satisfaction and quality for two populations with very medically complex and expensive conditions. This experience is limited with respect to geography, size, and the clinical profile of the populations served. Nonetheless, it suggests the potential efficacy of a radically different approach to public policy and care delivery—an approach that is relevant as Medicaid programs move aggressively to contract SSI-eligible recipients into managed care plans.

Currently, a predominant assumption of state Medicaid programs is that SSI-eligible disabled individuals have no features that distinguish them from their welfare-eligible or employed counterparts. Consequently,

**Figure 4.** Acute Hospital PMPM Costs for CMA Members With Severe Physical Disabilities (Medicaid Only): 1990-1991 (FFS) and 1992-1996 (Capitated)

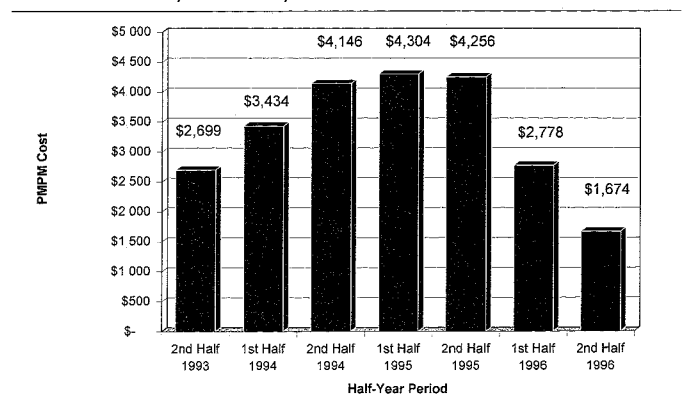


**Figure 5.** Distribution of Medical Service Expenditures for CMA Members With Severe Physical Disabilities (Medicaid Only)



CMA = Community Medical Alliance; DME = durable medical equipment; MH/SA = mental health/substance abuse; NP = nurse-practitioner.

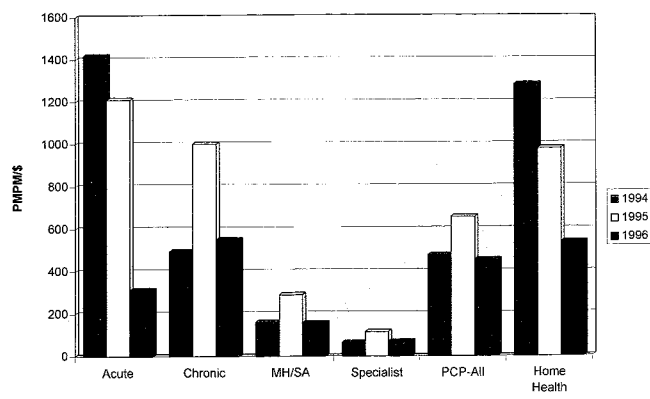
**Figure 6.** Total PMPM Costs for CMA Members with AIDS (Medicaid Only): January 1, 1993-December 31, 1996



MA = Community Medical Alliance; PMPM = per member per month.



**Figure 7.** PMPM Expenditures for CMA Members with AIDS (Medicaid Only): 1994-1996



CMA = Community Medical Alliance; MH/SH = mental health/substance abuse; NP = nurse-practitioner; PCP = *Pneumocystis carinii* pneumonia.

large numbers of the disabled now are being contracted to managed care plans without health status-adjusted capitation and without any procurement standards that embody some of the principles developed in the CMA experience. Similarly, a predominant impulse of managed care plans is to attempt to achieve savings not by redesign of care systems, but by the usual approaches of management overlays, benefit restrictions, and strong incentives to limit referrals to specialists and hospitals.

In our alternative view, Medicaid programs can promote through their rate setting and procurement standards incentives and indeed requirements for health plans to break the mold and innovate in care delivery with an emphasis on "rationalizing" rather than "rationing" care as a prime strategy. For Medicaid's vulnerable SSI-eligible populations, there is now a national policy and care delivery race to the "managed care finish line." Nine states are now or are about to contract their SSI-eligible patients into plans on a mandatory basis without any consideration of the potential mismatch of traditional health plans designed for healthy populations (who have intermittent healthcare needs) with the needs of disabled and chronically ill patients (who have continuous healthcare needs).

At the same time, a smaller subset of states (eg, Wisconsin, Missouri, Maryland, Colorado, Massachusetts) have invested in the more cumbersome, complex, and expensive processes of promoting through rate setting or procurement policies varying degrees of care delivery reform for Medicaid's SSI-eligible populations in those states. It remains to be seen what payment policy and care delivery approach will dominate in the years to come.

... REFERENCES ...

1. Kronick R, Zhiyian Z, Dreyfus T. Making risk adjustment work for everyone. *Inquiry* Spring 1995; 32:41-55.
2. Ash A, Porell F, Gruenberg L, Sawitz E, Beiser A. Adjusting Medicare capitation payments using prior hospitalizations data. *Health Care Financ Rev* Summer 1989;10:17-29.
3. Meyers AR, Glover M, Master RJ. The Community Medical Alliance (CMA), Boston's community Medical Group (BCMG), and the Boston model of prepaid, managed, primary care for independently living persons with major disabling conditions. *Am J Phys Med Rehabil* 1997;76(suppl); S37-S42.
4. Master R, Feltn M, Jainchill J, et al. A continuum of care for the inner city: Assessment of its benefit for Boston's elderly and high-risk populations. *N Engl J Med* 1980;302: 1434-1440.
5. Meyers AP, Cupples A, Lederman R, et al. A prospective evaluation of the effect of managed care on medical care utilization among severely disabled independently living adults. *Med Care* 1980;25:1057-1068.
6. Meyers A, Feltn M, Master R, et al. Rehospitalization and spinal cord injury: A cross-sectional survey of adults living independently. *Arch Phys Med Rehabil* 1985;66: 704-708.
7. Master R, Dreyfus T, Connors S, et al. The Community Medical Alliance: An integrated system of care in greater Boston for people with AIDS and severe disability. *Managed Care Q* 1996;4:26-37.
8. Master R. *Pneumocystis pneumonia* in a prepaid care system caring for a Medicaid covered population with AIDS. *J Ambulatory Care Manage* 1996;19:38-42.