In This Issue

THE MEDICARE AND MEDICAID PROGRAMS COVER acute- and long-term-care services for many of the most vulnerable members of our society: the elderly and persons of all ages with chronic illnesses and various types of disabilities. The politics of balancing the federal budget has made these programs the subject of intense scrutiny. As federal officials try to bring the nation's finances under control, it is critical that they consider the impact that program modifications would have on the sickest members of our society. The first three articles in this issue of the *Milbank Quarterly* present data and policy analyses that will be very helpful to persons who are evaluating, proposing, and even opposing, changes to Medicare and Medicaid.

Most people think of Medicaid primarily as an entitlement program that offers coverage to low-income mothers and children. Few realize that more than a third of Medicaid expenditures are allocated for long-term care, primarily of the elderly. Thus, any modifications to the program affect the choices, accessibility, and quality of long-term care, and they also have an impact on the out-of-pocket expenses that Medicaid beneficiaries must pay. Judith Feder and her colleagues, in "Medicaid and Long-Term Care for the Elderly: Implications for Restructuring," analyze the proposals considered during the 1995–96 congressional budget debates. They emphasize that changes in the Medicaid program could have important implications for the way in which long-term-care services are provided in the United States.

Although the role of Medicare in covering the costs of managing chronic illness has been familiar to most people for a while, in recent years the debate about how the program can constrain costs while continuing to pay for the necessary and appropriate services has become familiar as well. One current policy, that of encouraging the enrollment of Medicare recipients in managed care health plans, has been thoroughly covered both in the health policy literature and in the popular media. Critics have voiced concern, however, that these plans do not provide adequate services, either because they receive insufficient reimbursement for older patients with chronic conditions and/or because they selectively enroll healthier patients.

A partial solution would be to risk-adjust capitation payments in order to provide the necessary resources and incentives for the plans to offer high-quality services to older, sicker patients. Unfortunately, current risk-adjustment strategies account for less than one percent of the variation in costs for Medicare recipients. One of the best measures of overall health status, and a good predictor of health care needs and costs, is self-reported functional status. In "Disability and Medicare Costs of Elderly Persons," Korbin Liu, Susan Wall, and Douglas Wissoker analyze data from the Medicare Current Beneficiary Survey to estimate how well self-reported functional limitations predict Medicare costs and how these associations vary by health status and other patient characteristics.

The largest diagnostic group among recipients of Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) comprises persons with serious psychiatric disorders. In "Pathways to Disability Income among Persons with Severe, Persistent Psychiatric Disorders," Sue E. Estroff and her colleagues present results from a prospective study of a cohort of persons with major psychiatric disorders who were at an early stage of their illness at the time of their enrollment in the study. Contrary to accusations reported in the national media, persons who eventually receive disability benefits are indeed severely ill. There was scant abuse of coverage by people who lacked motivation to work or who did not need the support. The authors conclude that until more alternate resources are created for persons with psychiatrically related disabilities, SSI, SSDI, Medicare, and Medicaid constitute "bare necessities." Estroff's group shares a concern with other experts that many persons with severe impairments who are in desperate need of support will have their eligibility terminated as a result of current disability reviews.

This year we have published two articles in the *Quarterly* that focus on interactions between private health care organizations and public health agencies. Paul K. Halverson and his colleagues commented on the increasing numbers of such alliances in "Not-So-Strange Bedfellows: Models of Interaction between Managed Care Plans and Public Health Agencies" (75:1). They discussed ways of improving collaboration between the two types of organizations in order to promote more effective public health. In a subsequent issue (75:2), William E. Welton, Theodore A. Kantner, and Sheila Moriber Katz explored, in "Developing Tomorrow's Integrated Community Health Systems," the ways in which

population-based or public health services could coordinate efforts with medical primary care providers.

In the current issue, Gloria J. Bazzoli and her colleagues describe the workings of a number of public–private partnerships, which were revealed in a study they conducted of applicants to the Community Care Network program of the Hospital Research and Educational Trust. The results enabled Bazzoli and her coauthors to highlight the types of collaboration that were most likely to succeed and that held the most promise for future cooperation.

As health care budgets are reduced and the trend toward regionalizing certain health care services accelerates, rural communities have had to struggle to sustain comprehensive and affordable health care. To meet the challenge of their evolving circumstances, rural health care providers have adopted the strategy of forming voluntary networks. Ira Moscovice and his coauthors review a number of cooperative efforts, in "Understanding Integrated Rural Health Networks," and then highlight critical aspects of network formation and development.

Paul D. Cleary