
Satisfaction with Health Care of Dually Eligible Older Beneficiaries

Lynda C. Burton, Sc.D., Jonathan P. Weiner, Dr.P.H., John Folkemer, Judith Kasper, Ph.D.,
Pearl S. German, Sc.D., and Gregory D. Stevens, M.H.S.

Satisfaction with health care was compared for dually eligible older beneficiaries receiving care in three settings: a managed care organization (MCO) that is at risk for providing Medicare and Medicaid benefits (n=200); the fee-for-service (FFS) sector in the same ZIP Code (n=201); and respondents to the national Medicare Current Beneficiary Survey (MCBS) (n=531). Patients in the MCO were more likely to be highly satisfied in three domains—global quality, access to care, and technical skills—compared with patients in the local and national FFS study groups but fewer were highly satisfied with the interpersonal manner of their providers.

INTRODUCTION

Federal and State health policymakers face a significant challenge in purchasing high quality, cost efficient medical care for dually eligible older beneficiaries who receive both Medicare and Medicaid. In addition to cost efficiency and quality, payers want to assure that recipients are satisfied with the medical care. Dually eligible persons account for 38 percent of total expenditures by Medicare beneficiaries

even though they constitute no more than 20 percent of the population (Olin, Liu, and Merriman, 1999). Beyond health and cost outcomes, there is increasing interest in whether medical care can be delivered that beneficiaries will find satisfactory in terms of access to care, communication with the health providers, and confidence that their health needs are being met. This study reports on patient satisfaction of dually eligible older beneficiaries in a managed care setting, comparing their satisfaction with similar patients in the FFS system in their catchment area as well as with a national sample of dually eligible older persons.

Managed care is being tested as a possible vehicle for achieving optimal health and cost outcomes. From the Federal perspective, managed care is advanced as a cost efficient way to finance and deliver care to older beneficiaries through Medicare+Choice plans. Dually eligible beneficiaries remain underrepresented in these plans although their numbers are growing (Clark and Hulbert, 1998). State Medicaid program directors also are interested in finding lower cost but high quality ways to provide care to dually eligible beneficiaries for whom they are the payers. However, few, if any, managed care providers have marketed to dually eligible older beneficiaries exclusively except in demonstration programs supported with waivers from CMS. Because of their higher costs, more than twice non-dually eligible Medicare beneficiaries (Murray and Shatto, 1998), they are an undesirable group to market to when a relatively flat rate reimbursement structure

The authors are with the Health Services Research and Development Center, Johns Hopkins University School of Hygiene and Public Health, Department of Health Policy and Management, with the exception of John Folkemer who is with the Maryland Department of Health and Mental Hygiene. Support for this research was provided by The Robert Wood Johnson Foundation under Grant Number 032370. The views expressed in this article are those of the authors and do not necessarily reflect those of Johns Hopkins University, the Maryland Department of Health and Mental Hygiene, or the Centers for Medicare & Medicaid Services (CMS) (formerly known as the Health Care Financing Administration).

is in place which does not adjust for risk related to health status. From the patient's perspective, there are few financial incentives to join an health maintenance organization (HMO) since all of their care, including prescription medications, copayments, and deductibles, are covered by the Medicaid program. However, patients, providers and payers recognize the problems in the present system with fragmented care. From each of these perspectives—the Federal and State payers, the providers, and the patients—it is important to examine the limited experience with dually eligible older beneficiaries in managed care.

This article compares dually eligible older beneficiaries who receive care in a managed care setting with capitated risk contracts with both Medicare and Medicaid to dually eligible beneficiaries receiving care in the FFS system. The MCO, Elder Health, Inc., is a for-profit health clinic exclusively enrolling dually eligible older beneficiaries reimbursed under typical Medicare+Choice methods and a Medicaid HMO. The health clinic is financed by investors, taking risk without waivers of Federal Government regulations that provision of care can be organized and delivered to dually eligible persons with good outcomes in terms of health and satisfaction, leaving a profit margin for investors. An evaluation is underway which focuses on the reimbursement mechanisms and the costs to Federal and State government of providing care in Elder Health. The first in a series, this article focuses on patient satisfaction with this care, a critical element of quality care, and a goal of States and CMS. CMS has mandated that Medicare+Choice managed care plans (and, eventually, FFS providers) measure patient satisfaction with a Consumer Assessment of Health Plans Study, to provide consumers dependable information that will help them

make better choices about their health care (U.S. Department of Health and Human Services, 1997). In addition, patient satisfaction is necessary to encourage enrollment.

BACKGROUND

There have been several studies of satisfaction among older patients in managed care. Hall et al. (1990) found that satisfaction of older patients in HMOs was associated with good health and physical function, less emotional distress, and more social activity. Ward (1990) found that there was greater satisfaction among persons age 65 or over enrolled in HMOs, compared with persons under 65. Lee and Kasper (1998) used the MCBS to demonstrate that being older, black, less educated, and in poor health were factors associated with lower satisfaction.

Less is known about satisfaction of care of older dually eligible beneficiaries. Lee and Kasper (1998) noted greater satisfaction among older persons who were dually eligible than persons with Medicare only, private supplemental insurance, or other combinations of health insurance. Another study of elderly Medicare beneficiaries found that higher satisfaction with access and quality of care was associated with being in the FFS system while higher satisfaction with costs was associated with HMO enrollees (Kasper and Riley, 1992). This study was based primarily on non-dually eligible patients. Findings from the 1995 MCBS showed that dually eligible beneficiaries, compared with other Medicare beneficiaries, were more likely to have problems with access to care, even while reporting similar levels of satisfaction with care (Olin, Liu, and Merriman, 1999).

Methods

Setting and Population

The setting for the study was the catchment area for the two health clinics in Baltimore, Maryland of Elder Health, Inc., a private, entrepreneurial medical provider that takes risk for Medicare and Medicaid benefits for their fully dully eligible, older patients. The medical care objectives of Elder Health are to provide integrated, geriatrically-oriented health care by emphasizing prevention and primary care. Patients are assigned to a nurse practitioner and primary care physician who function as primary care providers. The nurse practitioner also functions as a case manager to integrate medical care and social services as needed. The nurse practitioner provides 24-hour/7-days-a-week first call coverage, although patients can go directly to their primary care physician. Specialist visits are subject to utilization review.

All of the services to which Medicare and Medicaid beneficiaries are entitled are provided under the capitation payments, except for institutional and community-based long-term care (LTC) which is reimbursed by the State FFS. The latter includes adult medical day care which is located at the medical centers. In addition to required benefits, Elder Health provides extensive transportation to medical appointments.

The health clinics opened in Baltimore in 1996, and in 1998 served about 400 persons in approximately one-half of the ZIP Code areas of the city. Patients enrolled in Elder Health have a choice of more than 300 doctors who are on its physician panel and credentialed by its HMO partner, Care First.

Elder Health has unique financing arrangements in that it combines Medicare and Medicaid capitation payments at the provider level and therefore has some dis-

cretion in the expenditure of funds. Because enrollment is voluntary, waivers from CMS were not required. Elder Health takes full financial responsibility for the delivery of Medicare and most Medicaid covered services under contract to Care First's Maryland Medicare and Medicaid HMO.

Study Design

The evaluation was based on structured in-home interviews with Elder Health patients ($n=200$) and a comparable group of dually eligible older patients in FFS ($n=201$) from October 1998 - March 1999. These local samples are compared with a national sample of fully dually eligible persons, age 65 or over, non-institutionalized persons in FFS ($n=531$) who completed the 1996 MCBS. This is a household survey conducted by CMS (Adler, 1994) which has Medicare claims data linked with the survey responses in the 1996 Access to Care Public Use Files.

Study Population

The study sample for Elder Health was selected from a randomly compiled list of patients who had been enrolled for at least 6 months, stratified by age, ZIP Code, and whether or not they received adult day health care. The comparison group was obtained from a randomly compiled list of patients from the same geographic area in the FFS system, stratified in the same manner, obtained from State Medicaid rolls. The FFS patients in both the local and national sample were selected based on their being FFS for both Medicare and Medicaid. A goal of 200 enrollees in each of the local groups was established based on available resources for the study. For the Elder Health sample, a list of 368 eligible persons was available: 246 eligible patients were contacted, with 200 completed interviews and

46 (18.7 percent) refusals. For the FFS comparison sample, a list of more than 3,900 persons who met age, ZIP Code, and community dwelling status was made available. Of 770 attempted contacts, 304 were located and eligible for the study. Of these, 202 completed interviews and 102 refused (33.6 percent). National dually eligible persons were drawn from the MCBS study population, based on their being fully dually eligible, age 65 or over and living in the community. This group was added to the study to compare whether the national population of dually eligible beneficiaries were similar to the local samples.

The study was approved by two institutional review boards: Johns Hopkins Committee on Human Volunteers and the Maryland State Department of Health and Mental Hygiene. Informed consent was obtained from subjects.

Measurement

Sociodemographics obtained included age, race, sex, marital status, education, income, and whether or not the patient was living alone. Health status was measured by self-reported health and with a general health status measure, the Quality of Well-Being Scale. This is a composite measure of health which includes symptoms, physical and social function, and mobility (Kaplan and Anderson, 1988). Cognitive status was obtained from the mini-mental State exam, which has been validated and used extensively with older persons (Folstein et al., 1985). Functional status was measured by self-reported activities of daily living (ADLs), (Katz et al., 1963) and instrumental activities of daily living (IADLs) (Lawton and Brody, 1969). Utilization of medical care is reported as visits to a medical office within the past 6 months, preventive services, whether

there was an emergency department visit within 3 months, hospitalization within the past year, and number of hospital days per year per 1,000 persons. All were obtained by self-report. Questions on patient satisfaction, access to care, and usual source of care were taken from the MCBS to enable comparisons with this national population.

Twenty questions related to satisfaction were consolidated into five domains identified by Lee and Kasper (1998): (1) global quality, (2) access to care, (3) technical skills, (4) interpersonal manner of health provider, and (5) information giving. Global quality includes overall quality of care, information given by provider, followup care, concern for overall health, and needs met at same location. Access to care includes availability at night and weekends, ease and convenience of appointments, and out-of-pocket costs. Technical skills relate to the patient's belief that his/her primary care provider checks everything, is competent, understands his/her medical history, and understands what is wrong medically. Interpersonal manner of health provider queries the patient on whether the doctor seems to be in a hurry, does not explain, does not discuss, acts like he/she is doing the patient a favor. Information giving includes whether the provider tells all the patient wants to know, answers all the patient's questions, has the confidence of the patient, and the patient depends on the provider.

Global quality and access to care are questions about the health care setting generally. Technical skills, interpersonal manner, and information giving relate to the patient's primary or usual physician. Since the model of care in Elder Health is heavily dependent on the nurse practitioner as a primary care provider, for Elder Health patients these questions referred to their nurse practitioner.

Each question had four response categories: very satisfied, satisfied, unsatisfied, and very unsatisfied. Distribution across the response categories was skewed for all groups. Typically, there were fewer than 15 percent respondents who reported being either unsatisfied or very unsatisfied in the 20 questions. To reduce data to a composite score, the ordinal scale was translated into interval data assuming equal value to the intervals between the categories. To detect variability, scores within one standard deviation (SD) of the mean were defined as moderately satisfied, and scores above and below the SD were defined as highly satisfied or dissatisfied. For use in regression analysis, a total satisfaction score was created by summing responses across the five domains.

Statistical Methods

Associations between the study groups and patient characteristics were tested for significance with the chi square for categorical variables and *t* tests for means. The chi square statistic was used to determine whether there was significant association between the study groups and the five satisfaction domains. Differences in the total satisfaction score by specific characteristics of the population were tested across the three study groups with the general linear models procedure for determination of differences among means (SAS Institute, 1998) which uses a Bonferroni *t* test to control for multiple comparisons. Ordinary least squares regression was used to determine if the independent variable, being in Elder Health, remained significantly associated with total satisfaction when other factors associated with satisfaction were controlled.

Results

Table 1 shows differences in the sociodemographics of the three groups. There were significantly more black persons in the Elder Health sample (93 percent) compared with the local FFS comparison sample (68 percent) and the national sample (29 percent). The Elder Health sample and the local FFS group were drawn from the same geographic area, approximately one-half of the ZIP Codes in the city, so the differences may be attributable to some aspect of the enrollment process. The MCBS group had a greater proportion of persons age 85 or over. The majority of all groups was female. A significantly lower proportion of persons in the local groups were married. A higher proportion of persons in the MCBS group had 0-8 years of education and a lower proportion had 9-11 years of education.

Self-reported health status was similar for the two Baltimore study groups but each of these groups differed from the national group by having fewer good and more fair responses. The Quality of Well Being Scale score, which measures general health and well-being, and the cognitive score were essentially the same for Elder Health and the local FFS group. These measures were not available for the national sample. In terms of physical functioning, the MCBS sample had a higher mean number of impairments in ADLs than either of the Baltimore groups.

Health services utilization varied. A smaller proportion of persons in both Elder Health and the FFS local comparison group reported emergency department visits (16 percent and 17 percent, respectively) compared with persons in the national sample (31 percent). A similar proportion of Elder Health patients and MCBS respondents reported a hospital-

Table 1
Comparison of Selected Characteristics of Dually Eligible Older Beneficiaries, by Managed Care and Fee-for-Service Study Group

Variable	Managed Care Elder Health (n=200)	Fee-for-Service	
		State FFS (n=201)	MCBS FFS (n=531)
Sociodemographic		Percent	
Age**			
65-74 Years	50.5	48.3	44.8
75-84 Years	39.0	40.3	35.0
85 Years or Over	10.5	11.4	20.2
Sex			
Female	79.5	81.2	74.4
Male	20.5	18.8	25.6
Married***	6.0	5.5	21.5
Race***			
White	6.0	29.7	56.5
Black	93.0	67.8	28.5
Other	1.0	2.5	15.4
Education*			
0-Eighth Grade	58.7	52.6	64.0
Ninth-Eleventh Grade	24.5	24.7	16.3
Greater or Equal to Twelfth Grade	16.8	22.7	19.8
Living Arrangements			
Alone	62.8	52.0	43.9
With Other:	37.2	48.0	56.1
Health Status			
Cognitive Score ¹ (Mean, Range 0-30)	24.7	25.1	NA
Quality of Well-Being Score ² (Mean, Range 0-1)	0.65	0.64	NA
Self-Reported Health***			
Excellent	8.5	8.4	8.7
Very Good	21.5	19.8	15.9
Good	28.5	24.3	33.8
Fair	34.5	33.2	21.7
Poor	7.0	14.4	19.8
Self-Reported Health (Mean, Range 0-5)	3.1	3.3	3.3
Physical Functioning			
ADLs (Mean [SD] for Tasks)***	0.5 (1.0)	0.6 (1.1)	1.0 (1.5)
ADLs (Mean [SD] for 6 Tasks)	1.6 (1.8)	1.9 (2.0)	1.9 (2.1)
Health Service Utilization			
Medical Visit ³ ***	100.0	92.5	80.2
Emergency Room Visit in Past 3 Months	15.5	16.9	31.1
Hospitalization in Last Year	22.0	15.8	21.7
Mean Number Hospital Days/1,000 ⁴	1,660	2,069	1,942
Preventive Services			
Mammogram in Past Year***	86.1	55.8	28.7
Pap Smear in Past Year***	75.5	47.5	21.1
Flu Shot Last Winter***	74.0	59.5	52.7
Pneumonia Vaccine Ever***	60.0	36.9	37.6

*= $p < 0.05$.

**= $p < 0.01$.

***= $p < 0.001$.

¹Cognitive score from Mini-Mental State Exam.

²Score from Quality of Well Being Scale.

³Medical doctor or nurse practitioner visit within past 6 months.

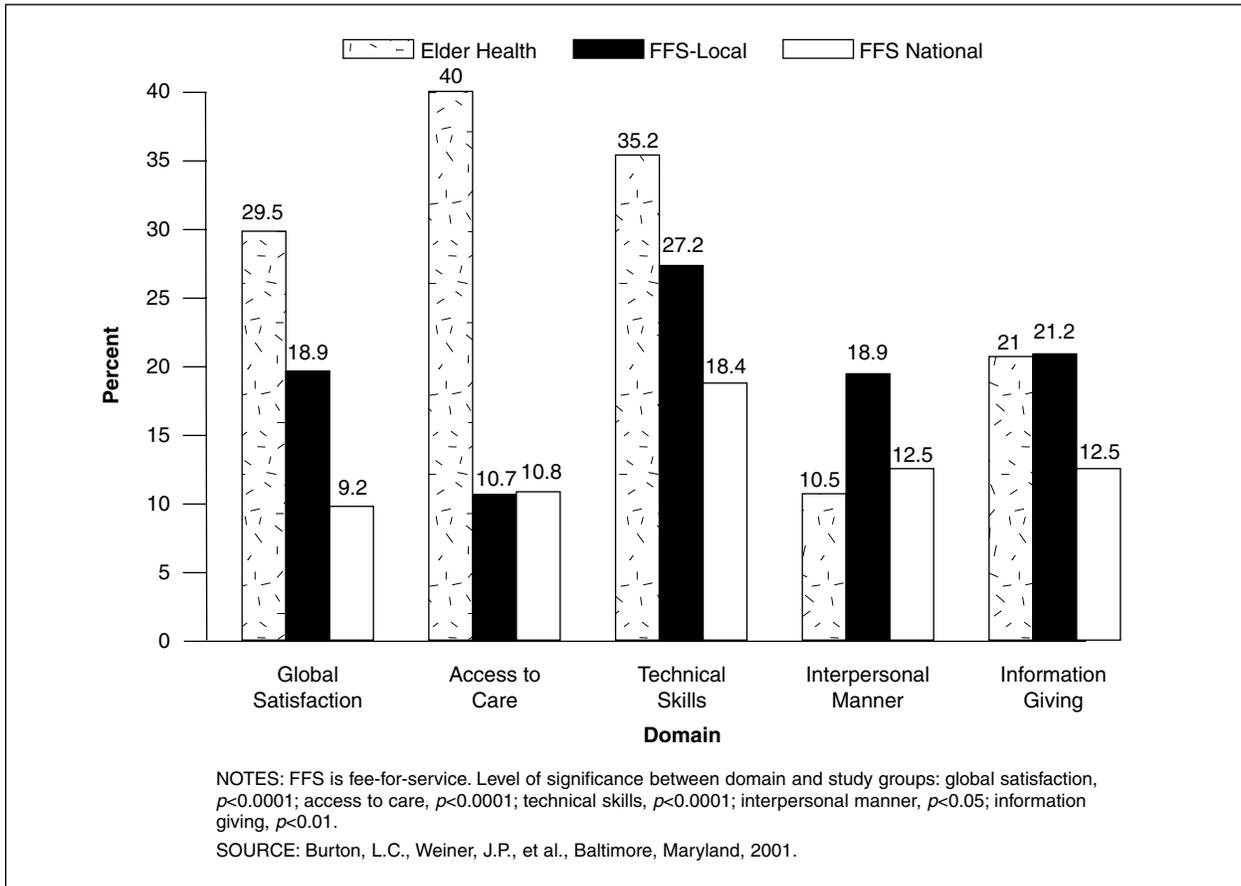
⁴Four individuals with number of hospital days beyond 2SDs from the mean removed.

NOTES: FFS is fee-for-service. MCBS is Medicare Current Beneficiary Survey. ADLs is activities of daily living. SD is standard deviation. IADLs is instrumental activities of daily living.

SOURCE: In-home interviews with patients enrolled in the managed care clinic and those in FFS all in Baltimore, Maryland, 1998-1999.

Figure 1

Percent Highly Satisfied with Care: Comparison of Elder Health and Local and National FFS Groups



ization in the past year (22 percent) compared with the local FFS group (16 percent). However, Elder Health and MCBS respondents had lower mean number of hospital days per 1,000 (1,660 and 1,942, respectively) compared with patients in the local FFS group (2,069). The usual source of care varied among the FFS groups, with the local FFS group receiving care from more varied sources (doctor office or clinic, health center, hospital out patient department) than the national sample in which 86 percent receive care from a doctor office or clinic visit.

A higher proportion of Elder Health patients reported receiving preventive services (mammogram, pap smear, or pneumonia vaccination) than patients in either FFS group: approximately 1.5 times the proportion of the local FFS group and 3

times the proportion of the national sample. The proportion of patients who received flu vaccinations was also highest for Elder Health compared with the FFS study groups.

Figure 1 compares satisfaction in five domains. Most importantly, the majority of patients in each of the study groups were either highly satisfied or satisfied with care. A greater proportion of Elder Health patients compared with the FFS groups were highly satisfied in three domains: global quality, access to care, and technical skills. However, a smaller proportion of Elder Health patients were highly satisfied with interpersonal manner than patients in the local comparison group. The relationship among the three study groups and satisfaction within a domain (global satisfac-

tion, access, technical skills, interpersonal manner, and information giving) was significant for all five domains.

A total satisfaction score was obtained for each individual by adding across the five domains, with a possible total score of 80 indicating very satisfied in all 20 questions. Mean scores by study group were: Elder Health, 64.7 (SD 7.5); local FFS comparison group, 63.0, (SD 7.8); and, national FFS comparison group, 61.5 (SD 6.1). Two analyses were conducted (not shown) to identify factors that contributed to total satisfaction among these dually eligible older beneficiaries. It was expected that differences in race might account for differences in satisfaction, given the marked difference in the proportion of black persons in the groups—Elder Health (93 percent), the local FFS patients (68 percent), and the national comparison group (29 percent). When total satisfaction scores were compared by race, black persons in Elder Health had significantly higher scores than the local and national FFS comparison groups (64.4, 61.9, 60.7, respectively; $p < 0.05$ in Bonferroni test of differences in means). A second analysis combined patients from all groups to determine what characteristics predicted total satisfaction. Like other studies of older populations, the factors significantly associated ($p < 0.05$, Bonferroni test of differences in means) with satisfaction were being younger, having more education, reporting good health, having fewer functional impairments, having a recent doctor visit, and having preventive services (mammography, pap smear, or pneumonia immunization). The patient's sex, marital status, and living arrangement were not significantly associated with total satisfaction.

Separate multivariate regressions were run to test whether being an Elder Health patient remained significantly associated with higher satisfaction when other vari-

ables known to be related to satisfaction were controlled. The results are shown in Table 2. In the first regression, which was limited to Elder Health and the local FFS comparison group, the parameter estimate for being in Elder Health as opposed to the local FFS group was 1.67 ($p < 0.001$) indicating Elder Health patients had on average 1.67 greater satisfaction points. Other variables which were significantly associated with satisfaction were: younger age, more education, being non-black, having better self-rated health, and having seen the primary health provider in the past 6 months. There were similar results in the regression that compared Elder Health and the national FFS comparison group.

DISCUSSION

As States consider moving their older dually eligible patients into managed care, there is concern regarding how patients will react. The MCO studied was unique in that it is a for-profit organization that operates without Federal Government waivers by enrolling persons on a voluntary basis and combines Medicare and Medicaid funds at the service level as a part of its integration of care. In addition, it serves an almost exclusively black population—a group that has been shown to be less satisfied with care in other FFS settings (Lee and Kasper, 1998).

This study found that dually eligible older beneficiaries were satisfied in the managed care plan studied, which tailored care to their needs including providing transportation for all types of medical visit, access to care via onsite nurse practitioners who functioned as primary care providers, and high levels of preventive services. Elder Health patients were significantly more satisfied with care compared with patients in both a local FFS compari-

Table 2
Factors Associated with Total Satisfaction¹ Among Dually Eligible Older Individuals

Factor	Parameter Estimate ²	p value
Elder Health and Local FFS Comparison Group		
Elder Health versus Local FFS	1.67	.0395
Self-Rated Health (1 to 5) ³	-1.26	.0003
Education ³	0.07	.5232
Age ³	-0.17	.0079
MD/NP Visit within 6 Months	5.98	.0254
Black (=1) versus Other (=0)	-2.39	.0172
Functional Status ⁴	-0.51	.0024
Elder Health and National FFS Comparison Group		
Elder Health versus National FFS	3.41	.0001
Self-Rated Health (1 to 5) ³	-0.81	.0008
Education ³	0.18	.0051
Age ³	-0.02	.6658
MD/NP Visit within 6 Months	0.96	.2573
Black (=1) versus Other (=0)	-0.94	.1363
Functional Status ⁴	-0.11	.2242

¹Total satisfaction defined as the sum of 8 questions on global quality and 12 questions related to health provider (MD or, for Elder Health patients, NP) taken from the Medicare Current Beneficiary Survey.

²Coefficients from multivariate regression.

³Continuous variables.

⁴Combined activity of daily living and instrumental activity of daily living score.

NOTES: FFS is fee-for-service. MD/NP is medical doctor/nurse practitioner.

SOURCE: In-home interviews with patients enrolled in the managed care clinic and those in FFS all in Baltimore, Maryland, 1998-1999.

son group and national FFS group, although differences were small. It is important to note that satisfaction levels were high for all three groups and, although the findings were statistically significant, the impact of a several point difference in a scale that ranges to 80 points may be small. A greater proportion of managed care patients were highly satisfied than both FFS groups in terms of global satisfaction and access to care (which reached statistical significance) and technical skills of their provider. Elder Health patients rated information giving at about the same level as both the State and national comparison groups. Interpersonal manner was rated somewhat lower.

At the bivariate level, we found evidence of total satisfaction being associated with use of preventive services as others have shown (Phillips et al., 2000) and having a recent doctor/nurse practitioner visit. Other studies have shown high socioeconomic status is inversely associated with satisfaction with care in an HMO (Carlson

et al., 2000). Our Medicaid populations, whose eligibility is related to low income, showed a positive effect of education. Better health and good functional status also had positive associations with satisfaction.

As in earlier studies of older populations, dually eligible beneficiaries were more satisfied if they were the younger old, in good health, had recent service use, had higher education, and had less functional impairment. Contrary to findings in earlier studies of older persons generally, satisfaction of the older dually eligible beneficiaries was not associated with being female or married. In earlier studies, being black predicted lower satisfaction (Lee and Kasper, 1998). Nevertheless, Elder Health respondents, 93 percent of whom were black, gave significantly higher total satisfaction scores than the others groups.

Satisfaction may be highly related to freedom of choice (Ullman et al., 1997), and the fact that enrollees in Elder Health made a decision to enroll in this managed care plan may have contributed to their sat-

isfaction following enrollment. Conversely, with a monthly option to disenroll mandated by Congress at the time of this study, beneficiaries who were dissatisfied may have disenrolled. This does not appear to be the case. Only three (1.5 percent) of the Elder Health enrollees who disenrolled during the year of the study cited provider issues as the reason, lower than national data on disenrollment (Riley, Ingber, and Tudor, 1997). Data on change of doctors or service providers among the FFS patients were not collected.

To our knowledge, these are the first published data on satisfaction with care specifically among dually eligible older beneficiaries in a managed care organization, comparing them with patients in FFS. The most salient finding is that dually eligible older beneficiaries can be highly satisfied with medical services in a managed care setting with the nurse practitioner model of primary care. It will be essential to determine whether such positive findings can be replicated in other settings. The attributes of care with which Elder Health patients were highly satisfied related to the model of care: overall quality of care, followup care, concern for overall health, needs met at the same location, availability at night and weekends, ease and convenience of appointments and out-of-pocket costs. These attributes were not in reference to a particular provider. A possible limitation of our study is that we considered the nurse practitioner in Elder Health as the primary care provider and it was the nurse practitioner who patients rated for technical skill, interpersonal manner, and information giving. However, these three domains were not significantly different from the FFS groups, which used ratings based on physicians. The fact that the differences in satisfaction were associated with aspects of the model of care, access and general quality, and not inter-

personal domains, may strengthen the possibility of successful replication of a model which uses nurse practitioners.

The MCBS dually eligible population was added to the study to understand how similar the local groups were to a national group, and to understand how differences in characteristics affected satisfaction. Nationally, dually eligible beneficiaries had a lower proportion of black persons, a characteristic that has been associated with lower satisfaction in non-dually eligible older beneficiaries (Lee and Kasper, 1998). This suggests that the local groups might have been expected to be less satisfied with care. The availability of MCBS data made possible a third comparison which provided a benchmark for satisfaction with care of dually eligible older beneficiaries. While this variability between the local and national groups, particularly in racial composition, lessens the ability to generalize from our study, it suggests that there is satisfaction across a broad range of dually eligible beneficiaries. A limitation of using the MCBS data is that the data were collected 2 years before the primary data collection for the study, raising the possibility that changes in satisfaction with managed care at the national level may have occurred during that time interval.

LTC is not included in the Medicaid capitation rate for Elder Health and therefore a unified payment mechanism such as in the Program for All-inclusive Care for the Elderly (Kane, Illston, and Miller, 1992) was not achieved. State policymakers understandably have great concern about how to integrate ongoing and expensive LTC in capitated payment systems and this is being explored in social HMO demonstration (Newcomer, Harrington, and Kane, 2000). The presence of adult medical day care programs at the sites of the ambulatory care clinics is a step toward integration of community-based LTC with acute

care at the patient level, albeit not at the payment level. The Elder Health experience with integrated care, while less than a total integration of acute and LTC, does offer a hint of what can be achieved by a private, for-profit entity attempting to achieve some level of integration typically only achieved in non-profit and/or government waiver programs.

Satisfaction of patients, while important, has not been persuasive for health policy-makers if it is coupled with higher costs and greater service utilization or undesirable outcomes such as institutionalization (Weissert and Hedrick, 1994). The comparative costs to Medicaid and Medicare for capitated care and FFS care for older, dually eligible beneficiaries is essential information prior to setting policy. If this continuing evaluation ultimately finds that costs are contained and health outcomes are satisfactory, the finding of high satisfaction among enrollees will be important and may encourage provider organizations such as Elder Health, Inc., to expand or startup.

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Reprint Requests: Lynda C. Burton, Sc. D., Johns Hopkins School of Hygiene and Public Health, Department of Health Policy and Management, 624 North Broadway, Baltimore, MD 21205. E-mail: lburton@jhsph.edu