Medicaid Prepayment: Concept and Implementation

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This paper examines the potential role of prepayment in the publicly financed delivery of health care to the poor under the Medicaid program. After briefly reviewing the theoretical advantages of prepayment for each of the principal participants: provider, funder, and user, the major implementation issues faced over the long term in actually realizing those advantages are discussed. The implementation issues are drawn from the experience gained in negotiations for conversion of the Martin Luther King, Jr., Neighborhood Health Center (MLK) in New York City to prepayment for its Medicaid population, supplemented by the results of the two large-scale Medicaid prepayment programs now in operation in New York City and California. The principal issues include (1) enrollment growth and rate of turnover, (2) underutilization of services, (3) out-of-plan use of services, (4) regulations of the quality of care, and (5) failure of the prepayment economic incentive. Two basic approaches to dealing with these issues are presented: a strong contractual agreement between the public agency and provider, and regular evaluation of the program. The major features of the Medicaid prepayment contract recently negotiated with MLK which attempts to ease these problems are reviewed in detail.

Prepayment of medical care has been strongly advocated as an effective approach to controlling the spiraling costs of health care. While prepayment can have beneficial impacts on quality of care as well, its dominant selling point has been the creation of a cost-control mechanism which relies on the "hidden hand" of economic incentives within the health delivery system, instead of an externally imposed regulation. The use of prepaid financing for this purpose in the Medicaid program is no longer a new concept. As of the end of 1973, New York City had had seven years of experience with prepayment of a limited benefit package in a contract with the Health Insurance Plan of Greater New York (Health Insurance Plan of Greater New York, 1972). Nationally, over 280,000 Medicaid-eligible people had been enrolled in prepaid plans in 12

states (Department of Health, Education, and Welfare [HEW], 1971; 1972a) with California alone having over 200,000 enrollees in 50 plans (California Department of Health Services, 1974).

Limited information on the utilization experience and costs of Medicaid prepayment programs have begun to appear (Shapiro et al., 1967; Greenlick et al., 1972; Gaus et al., 1972). However, as will be seen, all of this experience comes from special pilot or demonstration programs which have important differences from full-scale operations. Also, the experience published so far concentrates on the results of the demonstrations and gives little insight into the issues involved in establishing and operating the program successfully (Valiante, 1971; Colombo et al., 1969). What information is currently available from the large-scale California and New York programs, and what light can these results shed on the implementation of Medicaid prepayment on a significant scale? All of the attempts to establish Medicaid prepayment have encountered the familiar delays and multiple barriers associated with the red tape of public agencies. The questions which this paper tries to answer are, first, do implementation issues exist which cut across the particular idiosyncrasies of individual bureaucracies and are generic to the operation of large-scale Medicaid prepayment programs? Second, if such issues exist, what tools are available to deal with them, and, in particular, what is the role of the contract between the public agency and the provider?

The central theme of this paper is simple. Medicaid prepayment functions differently in many important ways from privately financed prepayment. The issues faced by the city of New York and an existing neighborhood health center in converting to Medicaid prepayment are developed in the section "Medicaid Prepayment: Implementation Issues" of this paper. The more important differences include the following:

1. *Enrollment and Turnover of Members.* Establishing, then maintaining an enrolled population is much more difficult for a combination of reasons. The Medicaid enrollee has no fiscal incentive to enroll because he pays no out-of-pocket costs; most of the providers offering the prepaid option will continue to provide care on a fee-for-service basis, so enrollment does not usually provide access to a better delivery system, etc. The problems in attracting new members are even more acute considering the high turnover in enrollment experienced by the large-scale programs. This turnover

is probably the greatest single threat to the concept of Medicaid prepayment. The attrition of members, often due to changes in eligibility that have nothing to do with the plan's performance, not only creates a greater demand for new enrollment, but more importantly makes it difficult if not impossible to educate enrollees on how to use the Health Plan and to provide continuity of treatment.

2. *Controls on Quality of Care.* The traditional quality controls in a prepaid group practice are much weaker for a Medicaid population. The public sector consequently bears a greater responsibility for regulating quality of care, yet there is real question about its ability to do so. None of the agencies responsible for Medicaid are capable today of monitoring to an adequate degee the quality of care delivered by a large-scale, multi-group, and geographically dispersed prepayment program.

3. *Fiscal Incentive.* The fiscal incentives which are supposed to spur the prepaid plan to better performance have yet to be effectively established in the public sector on a large-scale basis. The capitation rate which provides the target for the management of Medicaid prepayment plans to reach is being set in ways which leave them with questionable, if any, incentives. In addition, the termination clauses in the contract need to be modified to place the plan at greater risk.

The basic tool available to deal with these problems is the Medicaid prepayment contract entered into by the provider and the various agencies responsible for the Medicaid program. In the review of its Medicaid prepayment program, New York City has attempted to face explicitly the more important implementation issues by requiring a detailed contract supported by the necessary fiscal and quality of care monitoring. The contract, which as of July 1974 was still under review by the state, is the focus of the section "Dealing with Implementation Issues: The Medicaid Prepayment Contract." The contract incorporates explicit performance standards for the delivery of care, spells out how those standards are to be monitored both by the plan and by the city, and provides the sanctions for enforcing them. The fiscal incentives provided in the contract protect the plan from risk of loss in the first year of operation, but are intended to be revised after one year's experience. The problem of turnover due to eligibility changes is reduced, but not eliminated, by a guarantee of six months' enrollment.

The implementation issues discussed in this paper highlight two common misconceptions about Medicaid prepayment. First,

the impression that Medicaid prepayment is self-regulating is simply not supported by either theory or experience. It is often assumed that once a prepaid plan is established it can be essentially left to itself, that the contracting agency has only minimal responsibilities for monitoring the operation of the program. This assumption is not only false, it is dangerous. Prepayment does not eliminate the potential for abuse, it simply changes the form. The now familiar specter of overutilization in the fee-for-service program is replaced by the potential for underutilization and exclusion from needed care. Even setting aside the issue of deliberate abuse, the successful operation of prepayment depends upon key changes in the attitudes of the enrollees which have been difficult to promote in a well-educated middle-income population. The problems in reaching the medically indigent are even greater. Unless the need for regulation of both finances and quality of care is explicitly recognized, the prospects for successful introduction of Medicaid prepayment are remote.

Second, much of the published research on the results of Medicaid prepayment is of limited utility to large-scale operations. The vast majority of Medicaid prepayment contracts and all of the formal evaluations to date have been for small-scale programs. Except for California and New York City, the contracts have been demonstration programs involving one health center and a few thousand Medicaid enrollees. The special concessions made in setting up the demonstrations, e.g., guaranteed eligibility of all enrolled for the duration of the project, and the problems which only appear when the problem reaches a certain scale, make these demonstrations of very limited use in anticipating the implementation problems in state-wide or city-wide operations.

The observations presented here are tentative, and by no means definitive. They will certainly evolve with the anticipated improved evaluation of existing programs, the expansion into a wider variety of settings, and tighter administration by local agencies. On the basis of experience to date, properly monitored prepayment plans do offer the *potential* of improved health services to the medically indigent at lower cost. However, whether or not they will *continue* to offer significant cost savings, particularly in the face of tighter administration of fee-for-service hospital use through utilization review, remains to be seen.

Medicaid Prepayment: Implementation Issues

The essential characteristics of Medicaid prepayment are:

1. A comprehensive benefit plan, including inpatient and outpatient care
2. Prepayment of costs on a per capita basis
3. An enrolled population which agrees to obtain its medical care directly from, or under the supervision of, the prepaid health plan's doctors

Comparing this list to the typical neighborhood health center (NHC),the only ingredient missing is prepayment of costs to provide the desired financial incentives. The NHC already exists with the facilities and staff needed to deliver comprehensive services and the registered population to receive them. This greatly eases most of the start-up problems and provides an ideal site for testing prepayment with an indigent population (Borsody, 1972).

Because of the existence of several well-established NHCs in New York City, efforts on creating Medicaid prepayment focused on the possibility of converting the Medicaid financing of one of them from fee-for-service to prepaid capitation. After several months of exploring the feasibility at a number of centers, the work soon concentrated on the Martin Luther King, Jr., NHC (MLK) in the South Bronx.

The Medicaid contract referred to repeatedly in this paper is the agreement drawn up between New York City and MLK. The contract was designed as a model to be used in the future both for further conversions of existing centers, and for the development of new plans. The review of previous experience with Medicaid prepayment together with the extensive negotiations with the representatives of MLK that went into the creation of a sound model contract provided the foundations for this paper. However, as was stressed in the introduction, the discussion which follows has set aside the problems peculiar to New York City and MLK and centers on issues generic to large-scale Medicaid prepayment in any urban setting.

Theoretical Advantages of Medicaid Prepayment

The advantages offered by conversion to prepayment are quite dif-

ferent when viewed from the perspectives of the various primary actors involved. Yet, the full cooperation of all four of them—the providers, the consumers, the health plan, and the local agency—are required to make prepayment work. The providers, e.g., the medical group, hospital, etc., are not necessarily affected one way or the other and can play a neutral role. They can continue to be paid in the same way as before, although tighter standards and various incentives plans may be established by the plan to improve over-all performance.

In contrast, the consumers, particularly the current registrants of the center, are in a position of having to sacrifice something which may be quite important to them for very limited gains. Formally enrolling in a prepayment plan means giving up the freedom they now have of using Medicaid providers other than the Neighborhood Health Center when necessary or convenient. In return they receive no improvement in benefits, although schemes to give enrollees first priority in certain services are being considered. New registrants at the center will have the added inducement of receiving improved continuity of care through the center; however, it is not certain whether all new registrants can be required to become prepaid.

For the health plan, prepayment offers simplified administration because of the elimination of individual Medicaid claims, and the prospect of a regular, stabilized cash flow. Potentially, the experience gained with the Medicaid program would place it in a favorable position for the new HMO funding when and if that becomes available. However, prepayment definitely does *not* ease the funding squeeze created by the gradual cutbacks in funding of federal grants. Medicaid prepayment may offer slightly greater funds than Medicaid fee-for-service billing because of the elimination of disallowed claims and the potential for a modest incentive surplus. However, conversion to prepayment is essentially one funding source being substituted for another, not supplementing it. The issue of how to finance the care of the medically indigent who do not meet Medicaid eligibility requirements will have to be resolved in some other fashion. It will not be solved by Medicaid prepayment.

For the city, prepayment appears on the surface to offer nothing but positive effects. In theory, it should sharply reduce administrative loads by eliminating the processing and review of in-

dividual claims. However, the problem of out-of-plan use and monitoring of services already mentioned may just substitute a different type of need. The city also finds attractive the promise of more accurately targeted and more continuous medical care.

Granted that these effects are important, the major appeal from the city's perspective is the prospect for significant cost saving. Table 1 gives a detailed breakdown of the comparison between how Medicaid funds for the Aid to Dependent Children category were spent under fee-for-service, versus how they would be allocated under prepayment. As expected, the improved ambulatory care results in a total increase in per capita outpatient costs from $147 under fee-for-service to $205 under prepayment. However, this is more than offset by the reduction in inpatient care, yielding a net annual saving of $46, per enrollee even without compensating for two years of inflation.

Long-Term Implementation Issues

The implementation issues encountered in trying to realize the improvements just described can be divided into two classes: initial start-up and longer-term operations. Start-up problems for *conversion* to Medicaid prepayment are much smaller than for the typical full-scale development of a new organization from scratch, since there is the obvious advantage of having a facility, staff, and cash flow from the fee-for-service operations. However, the inevitable problems in changing a system from one structure to another still exist. They include legal obstacles, initial capital funding, initial enrollment, estimation of the capitation rate, etc.

Numerous technical assistance volumes (Department of Health, Education, and Welfare, 1972b) and articles (Valiente, 1971; Greenberg and Rodberg, 1971) have already been published detailing the steps involved in HMO development, so these problems will not be elaborated here.

However, when a Medicaid prepayment program becomes operational and enrolls its initial population, its trials are beginning, not ending. The center must successfully induce its members to use the services available. It must maintain its enrollment in the face of a geographically mobile population with ever changing eligibility for benefits. Finally, it must successfully manage the

TABLE 1
Comparison of Medicaid Expenditures:
Prepaid vs. Fee-for-Service

	1972 Fee-for-Service Medicaid Program		1974 Prepaid Medicaid Plan	
	$	%	$	%
Benefits in Prepayment Package				
Outpatient and physician care				
Physicians	69[a]	16.9	72	19.9
Optical	5	1.2	8	2.2
Lab and X-ray	16	3.9	16	4.4
Drugs	24	5.9	12	3.3
Administration[b]	28	6.8	70	19.3
Other[c]	5	1.2	12	3.3
Total outpatient	147	35.7	205	56.5
Inpatient care	187	45.7	110	30.3
Unaccounted fee-for-service[d]	27	6.6	–	–
Total cost: Benefits in prepaid package	361	88.3	315	86.8
Exclusions from Prepayment[e]				
Dental	16	3.9	16	3.9
Hospitalization[f]	30	7.3	30	7.3
Appliances	2	.5	2	.5
Total exclusions	48	11.7	48	11.7
Total cost: All benefits	409	100	363	100

[a] Includes $6.54 for podiatrist, $0.82 for visiting nurse, and $6.34 for other personnel.

[b] The figure for Fee-for-Service Administration is only OPD overhead and cannot be compared to overhead in the prepayment plan.

[c] Includes transportation, emergency care, out-of-area care, research and evaluation, etc.

[d] Only 93.4% of all expenditures were accounted for on the Department of Social Services reimbursement forms.

[e] The cost of excluded benefits are assumed to be the same under both programs. The mix of costs will change, but the total should remain constant.

[f] Exclusions for hospitalization in prepaid plan include alcoholism, drug addiction, tuberculosis, congenital defects, and chronic psychiatric disorders.

volume and quality of medical care delivered. The local agency, on its part, must monitor the performance of the plan and be prepared to periodically renegotiate the capitation rate. In areas with readily accessible public hospital systems, it must eliminate the use of out-of-plan service by prepayment enrollees.

The long-term problems of implementation described below flow from two major differences between prepayment in the private sector compared to prepayment in the public sector. First the significant changes in the incentives and mechanics of enrollment have been a persistent, troublesome problem. The obvious direct impact of enrollment difficulties is to slow the growth of the plan and threaten the financial stability of its operation. However, the damage to the delivery of medical care and to the basic incentives in the plan are equally serious. If, as has been the experience, the Medicaid enrollees turn over relatively quickly so that the plan does not have a stable population to work with and it finds itself losing enrollees because of changes in eligibility completely beyond its control, then the whole concept of prepayment is threatened. Both the financial and medical success of prepayment depend upon techniques which require time to absorb and continuity of population to be effective. Many of the difficulties with out-of-plan use and low utilization described below can be traced partially to enrollment and turnover problems.

The second difference, the greater need for accountability when dealing with public funds, creates problems principally because agencies are still only beginning to develop the capacity to meet their responsibilities. The basic tension operating in prepayment comes from the opposition of two forces: the financial incentive to reduce cost working against the moral imperative of maintaining reasonable standards of accessibility and quality of care. In Medicaid prepayment, the public agencies have a major role in maintaining *both* of these forces and ensuring that they remain balanced. Distinct problems in doing this have already appeared.

1. Enrollment Growth and Turnover. A center being converted from fee-for-service to prepayment begins with a group of patients familiar with the center. However, it still faces major problems in convincing that population to enroll in the prepaid plan. Enrollment is not automatic. Each individual recipient, or the person legally responsible for him, must voluntarily join the plan by sign-

ing a written agreement. The key clause in the agreement, and the reason for reluctance if the enrollee understands what he is doing, is a commitment to seek medical care *only* at the center. The center's staff may refer him elsewhere, but the patient can no longer exercise his own free choice and use his Medicaid card for drugs and services anywhere he chooses. For populations which have had poor access to care, or access to only poor care, this may not be a difficult sacrifice to make. But the center's currently registered population has had the best of both worlds—access to the center on a fee-for-service basis when they wanted, and also the discretion to use other providers when convenient. There is a valid question as to what old patients have to gain by enrolling in prepayment under such circumstances.

The problems encountered in enrolling Medicaid recipients into prepaid plans have been of two main types: first, the widely publicized enrollment abuses experienced in the California Medi-Cal program during the last two years (State of California, 1973), and, second, the problem of high turnover in enrollment. The problems are related, but each of them has different roots.

At one level the enrollment abuses in the Medi-Cal program were the result of special conditions which can be avoided. Better screening of the applicants for prepaid health plan contractors could weed out more of the groups entering the program for a quick financial gain. More reasonable limits on level of competition could avoid the debacle of 12 separate plans competing for enrollees in the same service area. These two simple remedies should eliminate some of the forces which created the problems in California. However, even with these steps the fundamental problem remains: the incentives to the patient to enroll in a prepaid plan which is not radically different from his existing source of care are nil. If Medicaid prepayment is primarily a financial change, converting an existing neighborhood health center or loosely affiliated medical group to capitation financing, enrollment problems are likely to create a strong incentive for abuse.

The aggressive competition between plans is one of the explanations for the high turnover in the Medi-Cal prepayment program enrollment (an average of 6 to 8 percent per *month* depending upon whom you talk to). However, even if the voluntary losses were completely eliminated, the turnover rate in the Medi-Cal program would still be in the range of 3 to 4 percent per month because of disenrollments due to loss of eligibility. This agrees with past ex-

perience in New York City where the Health Insurance Plan of Greater New York (HIP) has frequently complained about the level of involuntary disenrollments. The city's Department of Social Services estimates that only 70 percent of the ADC case load is continuously eligible for one year. Making a modest allowance for voluntary disenrollments, and considering that the turnover rate for HIP's regular population was 18 percent per year in 1971, the turnover of Medicaid enrollees is likely to be a minimum of twice as large as the non-Medicaid population.

A number of the Medicaid prepayment demonstration projects have solved this problem by guaranteeing enrollment for a minimum period ranging from six months to three years. Given the initial effort involved in enrolling, providing deferred medical care, and educating new subscribers, six months should be a minimum enrollment and one year would be preferable. While state welfare departments are willing to agree to such arrangements on a demonstration basis, the increasing impetus for economy in public assistance and Medicaid programs makes them quite firm in refusing it on any large scale.

2. *Utilization of Services.*The concerns about levels of utilization under Medicaid prepayment are twofold. First, many of the medical and financial benefits of prepayment are conditioned upon shifts in the pattern of utilization. Studies over the last 20 years have established that prepayment for the non-poor leads to little change in the volume of ambulatory care (although the distribution among ages and services shifts), and significant declines in hospital use (Donabedian, 1969a; Klarman, 1971). Given a well-conceived prepaid delivery system, will Medicaid enrollees behave similarly? Second, one of the chief potential abuses under prepayment is the provider's restricting access to care and thus limiting utilization. The restrictions can occur in a variety of ways and are not necessarily a sign of deliberate malintent. The concern here is, will the provider make the effort involved in educating its Medicaid enrollees about the benefits they are entitled to, and then actually make those services readily available?

Previously published evaluations have demonstrated that Medicaid prepayment can have similar impacts on utilization by the medically indigent as that found for the non-poor, at least on a pilot basis. Gaus et al. (1972) found significant changes in all four

categories of utilization which he reviewed—physician encounters, hospital admissions, hospital patient days, and drugs and prescriptions. The average number of physician encounters for the enrollees as a whole increased only slightly, from 3.64 visits/year before enrollment to 3.85 visits/year afterward, but the distribution of visits by age had major shifts. Hospital admission rates declined by 45 percent and patient day rates were reduced 31 percent to 608 days per year per 1000 enrollees. Although these results were based on only six months' experience under prepayment, a follow-up study using 18 months' experience is producing similar results.

Similarly, two published comparisons (Sparer and Anderson, 1972; Greenlick et al., 1972) of the experience of Medicaid enrollees to regular enrollees of the same plan show that prepayment can lead to similar utilization behavior for both populations in small-scale demonstrations. (The conclusion is somewhat misleading since the Medicaid plans described in the studies below placed a priority on selection of larger, high-risk families with current illness or recent pregnancy. Thus, the Medicaid enrollees should have had a higher than average use of care.) Sparer and Anderson review 18 months' experience at Kaiser-Portland, Kaiser-Fontains, Group Health of Puget Sound, and HIP/Suffolk County (a special demonstration program which should not be confused with the New York City contract). They show the expected pattern of use of physician services and hospital inpatient days at levels roughly comparable to regular subscribers, and a significantly reduced number of hospital inpatient days as compared to national levels. The data on the two populations is not strictly comparable, because the Medicaid and regular enrollees have different age distributions, but it should indicate the general results. Greenlick's study of the experience of the Kaiser-Portland program again confirmed that the rates and patterns of utilization of physician services for Medicaid and regular enrollees were essentially similar.

One shortcoming of the above experience is that it is drawn from relatively small samples of consumers enrolled in only one group for each of the contracts. What happens when Medicaid prepayment is implemented on a large scale involving dozens of relatively independent medical groups? Furthermore, what happens if these groups must operate in the presence of a large medical

system which has traditionally been the source of care for the medically indigent? The New York City-HIP contract provides one example, although the implications are limited, since HIP has not been responsible for hospital costs. Since 1967, HIP has had more than 50,000 Medicaid enrollees receiving services from a network of approximately 30 medical groups dispersed across New York City. The physician utilization by the Medicaid enrollees has been between one half and two thirds of that of regular HIP subscribers during the last five years of the program. Table 2 shows comparative age-specific utilization data for 1972, which indicates that the underutilization is most serious in the younger age categories, for whom preventive care is most important.

TABLE 2
Physician Utilization Rates (Services per Person per Year) by Age for HIP Medicaid and Non-Medicaid Enrollees, 1972

Age	Medicaid	Non-Medicaid	Ratio of Medicaid Rate to Non-Medicaid (%)
Total	2.3[a]	3.8	.62
0-4	3.0	5.3	58
5-14	1.2	2.5	46
15-24	1.4	3.0	45
25-44	2.7	3.6	74
45-64	4.0	5.0	81

[a] Adjusted to the age-sex composition of the non-Medicaid enrollment below age 65.

These data indicate a potentially serious underutilization but are insufficient to describe the problem adequately, much less explain it. For example, are the low average utilization rates the result of low utilization by everyone, or of extremely low use by a small fraction of the population and relatively normal use by the rest? It appears that the latter might well be the case, and the HIP Medicaid population is composed of two quite different groups.

One group is active in the program and receives care like other HIP enrollees, while the other for all practical purposes is not participating in the program. (There is reason to suspect that some of them even believe that they have disenrolled from it.) Data on the distribution of frequency of use of services is now being collected to clarify exactly what the problem is.

What are some of the possible causes for this low utilization? The high turnover in enrollment has already been discussed; the problem of out-of-plan use is discussed below. In addition, the basic flaw of the lack of commitment of a Medicaid enrollee who joins the plan just by signing his name with no real financial commitment is a factor which cannot be overlooked. In discussing this problem with the city, HIP has cited the problems of enrollment turnover, and the difficulty in breaking the habit of using hospital emergency rooms.

3. Out-of-Plan Use of Care. The physician utilization rates for HIP Medicaid enrollees of 2.3 visits per year is substantially below the norm for low-income groups in either New York City or the country. Are the enrollees simply not getting medical care, or are they going elsewhere? To answer this question, the city's Department of Social Services ran a special check on a sample of outpatient claims submitted to it by Medicaid fee-for-service providers to see how many services were being delivered to HIP Medicaid enrollees. The claims had not necessarily been paid, because a computer check had been made to disallow fee-for-service claims made for prepaid-plan enrollees. However, the data on the volume of out-of-HIP services had never been aggregated before for the purpose of determining the magnitude of out-of-plan use.

The results are shown in Table 3. The sample data drawn indicate that HIP has supplied approximately one third of the physician services received by its Medicaid enrollees. If it had paid the claims, the city would have paid other providers for claims a sum greater than the HIP capitation payments. Some of these services and claims are valid because the benefit package covered by the capitation contract does exclude some services, but this can only account for a small fraction of out-of-plan use shown in Table 3. It should be emphasized that the data in Table 3 are subject to some question. The total per capita utilization of almost six visits per year is higher than would be expected, even in New York City, and

TABLE 3
Annual Out-of-Plan Utilization by HIP Medicaid Enrollees at Fee-for-Service Providers, 1973

	Per Capita Visits	Cost per Visit	Total Cost
Out of HIP			
1. Voluntary hospital clinics[a]	1.3	$29.40	$2,200,000
2. Municipal hospital clinics[b]	.7	$28.40	$1,000,000
3. Private physicians[b]	1.8	N/A	N/A
Total	3.8		$3,200,000
In HIP	2.0	$34.50	$3,900,000
Total Utilization	5.8		$7,100,000 ($127/enrollee)

[a] Estimate based on one-month sample of bills

[b] Estimate based on five-month sample of bills

is a sign that the sample was not representative. While the data should not be used as a measure of the exact magnitude of the problem, it is a reliable indicator that the out-of-plan use is substantial.

While leakage is a common problem in prepaid plans, the difference here is that once again, the Medicaid enrollee bears no cost. If a Kaiser member decides that he wants to use his old family doctor around the corner instead of traveling to the medical center, he personally pays the bill. If a Medicaid member makes a similar decision, the city usually ends up bearing the cost and effectively makes a double payment for the same service. Some have proposed dealing with this by making the center responsible for the costs of all outside use, but its lack of control over outside providers makes this a dubious proposal.

4. Regulation of Quality of Medical Care. In theory, a prepaid plan increases the quality of services by more effective central management of the care a patient received as he moves through the fragmented delivery system. Improved centralized medical records, continuity of physician care within the center and between

center and hospital, increased preventive care, and other benefits are supposed to flow from prepayment. Whether they do or not when prepayment is introduced on a large scale no one knows, because neither New York City nor California has made serious attempts to find out. From the limited information available, it would appear that these improvements have not materialized, if for no other reason that little attention was devoted to ensuring that they would when the contracts were initially written.

In New York City, the omission of hospital costs from HIP's benefits greatly weakened HIP's responsibility for one of the crucial transitions in the modern medical system, that from outpatient to inpatient. HIP is still supposedly responsible for physician services in the hospital, but the data indicate that this is one of the areas of underutilization. In 1971 Medicaid enrollees received an average of .2 physician services in the hospital, compared to .4 for the non-Medicaid population under 65. The skew of the Medicaid age distribution toward a younger population would account for some difference in frequency of hospitalization, but it appears that the HIP Medicaid population is receiving approximately one half the HIP physician services in hospital of the non-Medicaid population.

Statistics on utilization can at most provide crude indicators on the quality of services supplied to enrollees. Answering the question as to the adequacy of services delivered requires standards for care, utilization measures, and sophisticated reporting systems which are only beginning to be implemented on a pilot basis. They do not exist in either the New York or California program. An exhaustive evaluation of care would have to be modeled to consider all facets—accessibility, comprehensiveness, continuity, efficiency, quality, and responsiveness (Donabedian, 1969). Simple utilization measures, such as average physician visits and days hospitalized, are only a first step in such an evaluation. They measure only quantity, not quality.

New York City has recently begun a regular program of annual site visits by Department of Health evaluation teams, which include a very limited chart review. This program will greatly improve the city's understanding of the variations in the structure and operation of the HIP medical groups but is only a first step in trying to improve the monitoring and regulation of the quality of care delivered under prepayment. The steps being taken to incorporate ex-

plicit standards of care into the prepayment contract which can be enforced by the city are discussed in the next section.

Some would argue that such explicit monitoring is the wrong approach. Alternatives such as internal regulation by the plan itself through peer review, effective consumer grievance processes, and dual choice allowing subscribers to leave the plan when dissatisfied are pointed to as more natural alternatives. These techniques are important, and if the plan is functioning correctly will in fact be the routine method for dealing with quality-of-care issues. However, they cannot always be relied upon to function automatically. For example, dual choice for Medicaid patients is often the choice between poor care or no care. Even if alternative providers are available, the bureaucratic obstacles to disenrolling severely limit its effectiveness as a check on poor services. Effective outside monitoring is necessary to ensure that internal controls are put into practice and continue to be effective over the long run. The debate over governmental "interference" in regulating quality of care paid for through Medicaid and Medicare has continued since the beginning of the programs. The fee-for-service Medicaid program has already established the need for outside regulations (O'Rourke et al., 1969). The shift to prepaid financing only changes the nature of the task; it does not eliminate it.

5. Failure of the Prepayment Economic Incentive. The essence of prepayment is risk; if the plan fails to deliver the services at cost within the agreed capitation rate, the plan must make up the difference. Behind this lies the assumption that the capitation rate was originally negotiated by fully informed parties with both the plan and the local agency agreeing on the levels of utilization and costs which were the basis of the capitation. Plans in operation for several years will periodically have to renegotiate the capitation rate as unit costs change or the plan's understanding of the needs of its population evolve. The periodic renegotiations limit the risk to the plan because it is virtually impossible to distinguish costs for providing quality care from unnecessary costs. An effective negotiation presupposes the ability to make this distinction.

The initial estimate of a capitation rate for a Medicaid population is just that, an estimate rather than a precise calculation. Different groups have taken widely different approaches to this problem, ranging from simply using the local per capita fee-for-service

costs to detailed actuarial studies. Unfortunately, the latter gives an illusion of a high degree of precision in our understanding of use of services. In fact, the actuarial data available for utilization of health services is in much poorer shape than that for life insurance. The data which does exist is generally not applicable to the medically indigent, and especially not to a medically indigent population receiving services from a prepaid group practice. The Medicaid fee-for-service utilization data which many hope to use for such estimates is often not in a reliable usable form. Even if it were, it would provide little insight into the utilization patterns which should be expected under prepayment.

Under such circumstances it is difficult to put a plan at risk until it has obtained some experience with its population. California's use of its local per capita fee-for-service costs, or New York's use of the city employee premium are as reasonable a starting point for a Medicaid capitation as utilization based estimates. However, after a year or two of operation, both the plan and the agency should be in a position to calculate a much more precise capitation rate. The failure to do so means that the need of the plan to manage the delivery of services to meet meaningful cost targets is greatly weakened and can be nonexistent.

The form of the contractual commitment provides a second factor which greatly reduces the risk to the plan. Most of the agreements now in operation allow renegotiation of the capitation rate at any time and termination of the contract on short (thirty days) notice. The effective result is that if the plan finds that its cost are running in excess of capitation, it can terminate the agreement if the local agency refuses to increase the capitation rate. The risk under such an agreement is minimal. It is infeasible to expect any plan to lock itself into a capitation rate until it has established some experience with its population. However, after one or two years' experience, it should be willing to guarantee a capitation rate for a year and put itself at risk, both for potential gains from good management and for losses due to poor control. In this case of nonprofit plans, the issue of who really carries, or should carry, this risk of loss is an unresolved ethical question. If the plan ends the year with a deficit, the group most likely to bear the brunt of the poor management is the fee-for-service registrants who will have to put up with service reduction as the center economizes. Is this fair?

If not, what are the general implications for non-profit providers serving mixed prepaid and fee-for-service populations?

Dealing with Implementation Issues: The Medicaid Prepayment Contract

The techniques for dealing with the longer-term problems outlined above do not necessarily have to be sophisticated or elaborate. An initial attack is yet to be made using two standard instruments: the contract establishing each Medicaid prepayment program and regular evaluation of its operation. These two tools by themselves cannot resolve all the problems. Even if every provision of the contract were fulfilled, it would still be only a partial solution. In particular, the issues of high enrollee turnover and effective monitoring of quality of care will persist. However, the combination of more carefully negotiated and enforced contracts, together with regular evaluation of their results, still offers much unrealized potential for understanding and controlling the operational problems in Medicaid prepayment.

The Medicaid Prepayment Contract

The Medicaid prepayment contracts in force today range from simple brief agreements of only a few pages which do little more than spell out the available benefits and the capitation rate, to massive documents running fifty pages or more. After a review of a dozen contracts, including a model contract prepared by a public-interest law group (Stern, 1973), it became clear that the price of brevity was ambiguity. Given the importance of monitoring such vague parameters as quality of care, this ambiguity was antithetical to the effective operation of the plan.

A contract is a compromise between parties with fundamentally different perspectives and self-interest. Properly designed, it protects the interests of both parties in a mutually satisfactory way. The emphasis here is on the measures protecting the public interest in general and the enrollees in particular. During the

negotiations with MKL equal weight had to be given to measures protecting the plan's interests, particularly to ensure fair payments for their services and to give them recourse from arbitrary abuse by the sometimes vague standards written into the contract.

The New York City contract which resulted contains the usual expected sections spelling out benefits, enrollment and disenrollment procedures, provisions for payment of capitation, termination and/or renegotiation, etc. However, in addition it includes four provisions which are unusual enough to be described in more detail. The intent of the clauses is to provide a tool for ensuring that the reality of Medicaid prepayment more closely approximates the theory, especially in large-volume programs where the informal controls on quality and costs which operate in a small-scale demonstration are no longer effective. Two of the provisions deal with the issue of quality of care, first by spelling out in detail performance and structural standards which must be met by the plan, then by providing for outside evaluation and financial sanctions to enforce the standards. The third clause provides for a graduated set of penalties to enforce the contract. The fourth clause attempts to strengthen the financial incentive which is supposedly the heart of prepayment.

1. Standards for Quality of Care. No one with any responsibility for regulating health care delivery would pretend that the standards or monitoring tools currently available are adequate to determine the quality of medical care being delivered to each of a significant number of the patients serviced by a health center. At best, the evaluator can only hope to establish the patterns of care delivered by the center by monitoring certain basic characteristics of its operation. The new Medicaid prepayment contract spells out explicitly what will be required of health care providers using standards based on indirect methods of evaluating delivery patterns, i.e., *structure* and *process* instead of the more elusive *output* measures. The clauses in the specific contract negotiated with MLK are not rigid codes to be applied across the board to every provider. Any one of the provisions could be substantially modified or even dropped without necessarily weakening the agreement; the elimination of all of them would, however, be a major change.

Their inclusion serves a number of purposes, with the first being the belief that structure and process are correlated with the

quality of health care delivered. Second, even if the technical quality is not improved greatly, many of the provisions enhance the dignity of and amenities for the patients. In essence, the standards make the contract an enforceable agreement instead of a vague document in which one very specific quantity, the capitation rate, is exchanged for a very undefined one, "high-quality medical care." Since the indicators of the quality of performance of a health provider are so poorly defined, the negotiation of specific standards is one means of clarifying exactly what the center's responsibilities are. The particular combination of provisions worked out for MLK is a compromise between what the Department of Health evaluation teams believed was necessary and what the MLK staff believed was feasible and applicable to their specific facility. Both groups entered the negotiations with quite different positions on the basis for the evaluation of the center as a health delivery system. The contract negotiations have forced them to find a common ground, *before* the prepaid plan began operation.

An examination of the other Medicaid prepayment agreements now in force shows that virtually all of them have ignored this question (California has a specific set of guidelines incorporated in Title 22 of the California Administrative Code); other than requiring that the facilities and providers be licensed as required by state law, the only specific requirements they share is that the center maintain a minimum physician/enrollee ratio (usually in the range of one full-time physician for each 1,000 to 1,500 enrollees). Although the quality of delivery of services is mentioned, it is usually limited to a brief phrase noting that "services will be administered in accordance with accepted medical practices," and that the center will ensure availability of services by maintaining adequate facilities and staff and operating the center in an efficient manner. Recognizing the danger of proliferating rigid codes and standards which take on a life of their own and can evolve into constraints which needlessly tie the hands of the provider, a contract must be more specific than that. Enough is known about the desirable operation of a modern health delivery system to introduce performance standards which provide meaningful indicators on the operation of the plan.

The standards included in the New York City prepayment contract were based on three years of experience of the Department of Health Evaluation and Institutional Review Program teams which

monitor providers throughout the city. The ambulatory-care performance standards in the prepayment contract deal with availability and accessibility of health services, efficiency of operations, health maintenance, and continuity of care. For example, the section on accessibility to care specifies that the center be open for service seven days a week, and has provisions ensuring ready access to unit medical records, laboratory services, radiology services, pharmacy, and social services. The section on continuity of care spells out the use of primary health care, the integration of walk-ins into the normal delivery system, the use of an appointment system with maximum delays of two weeks for routine appointments, and waiting times of no more than one half hour.

The provisions for continuity of care between the ambulatory center and hospital emphasize the creation of "Affiliate Hospitals" which have made formal agreements with the Neighborhood Health Center covering reimbursement, transfers of patients and medical records, etc. These agreements are subject to review by the Commissioner of Health, and in addition the center must ensure that:

—not less than 75 percent of the full time and part time Neighborhood Health Center physicians shall have admitting privileges in at least one Affiliated Hospital.

—A Neighborhood Health Center physician shall be the physician of record, and a member of the primary health team responsible for the patient in the center shall be available to provide continuity of care of the patient while the patient is at an inpatient service.

—Total hospitalization of enrolled persons in non-affiliated hospitals shall not exceed 33 percent of total hospital days, excluding extended care facilities and out of area emergencies.

2. *Monitoring of Quality of Care.* The contract includes the standard techniques for monitoring the quality of care—establishment of peer review and regular review within the plan itself, well-defined consumer-grievance procedures, the operation of a consumer/provider committee and review by the Department of Health of agreements with other providers. It also outlines a scheme for regular reporting on utilization of services, emphasizing information which will allow both the plan and the local agency to

know who is not receiving care. Average utilization figures obtained by dividing total use by total enrollment can mask unusual distributions of care among the population as a whole and specific age groups. Most of the data to be submitted by the plan emphasize gross statistics which are of little use to either the managers of the plan or the local agency in evaluating performance. Utilization data on the distribution of frequency of ambulatory services (how many enrollees have used the plan no times last year, how many used it 15 times or more?), on the age-specific use of ambulatory services, and on rates of hospital admissions and inpatient days by age groups and for specific diagnosis are not ultimate measures of quality of care, but they can indicate potential problems.

In order to monitor the performance standards discussed above, as well as follow up on potential problems identified through statistical reports, consumer grievances, or other means, a full-scale site visit to the plan's facilities will be made on a regular basis. New York City's Department of Health has been developing the capability to conduct such evaluations for hospital outpatient departments, nursing homes, private practitioners, and group practices which are financed through a variety of public programs. The exact format and protocol for the visit varies with the facility being evaluated but consists basically of a team of approximately six professionals spending one to two days at a facility interviewing its staff, collecting data on the operation of the center, and doing a limited review of medical charts. The administration of the center has to prepare some of the data in advance, and the results are based on about one month of analysis and interpretation of the data after the site visit. The contract mandates a minimum of one site visit a year, but visits can be scheduled more frequently if needed.

3. Enforcement of Standards: Partial Default. Given standards for the delivery of care and some initial tools to begin monitoring them, the third component of an enforcement system is a fair process for administering them. The contract specifies that the city has the right to declare the plan in partial default and withhold funds on thirty days' notice if it believes that the plan is not delivering the services as specified in the contract. If the plan disagrees with the city's judgment, it has the option of appealing to an outside arbitration board. California's standard contract contains provisions for a

wider variety of sanctions, for example, restricting new enrollment. However, New York City believed that the simple fiscal sanction was more than adequate.

4. Prepayment Economic Incentive. On a superficial reading it would appear that the New York City Medicaid prepayment contract explicitly incorporates both the potential for financial gain and the risk of losses on the part of the plan. In its clause dealing with excess funds and payment deficits, the contract provides that if the center is successful in keeping its costs at the end of the contract year below the capitation rate it can retain the excess (up to 5 percent of the total capitation) for the purpose of providing additional and improved services within the center. Since the contract is a demonstration, the risk of the plan for bearing losses is reduced by capitalization of a reserve fund (equal to 10 percent of the total capitation paid under the contract) that can be used for absorbing losses if the contract is terminated or canceled. Any deficits beyond the 10 percent reserve have to be borne by the plan. After the first year or so of operation, the intent is to eliminate or substantially reduce the reserve so the plan will be at greater risk.

These clauses are not nearly as effective as might appear, however. First, the plan has the option of canceling the contract on only one day's notice. If at any time it believes its experience is becoming unfavorable, it can end the agreement well before exhausting the reserve. Second, the crucial factor determining the risk of the plan is, of course, the capitation rate. If it is set high enough, the center is almost guaranteed to have excess funds and no risk at all of a deficit. One of the rationales for the demonstration contract was to establish the experience and costs for the enrolled population, so that the capitation could be set more precisely in the future and the plan would have real targets to meet in administering the plan. Doing this will be difficult however, because the Medicaid enrollees are going to be only one portion, and a minority at that, of the plan's total users. It will continue to deliver services to Medicaid-eligible registrants who do not elect to enroll in the prepayment plan, and to the non-Medicaid medically indigent whose care is paid for by HEW funds. The utilization of the prepaid enrollees can be separated out, but making any precise estimate of the costs of providing those services will be difficult. A

fiscal reporting system which allows the city to separate out the costs of the prepaid enrollees is now being designed, but the flexibility to allocate costs among three different sources of funds makes the prospects for a precise accounting small. This problem is being worked on now. Its importance will not be known for certain until more information is available on the size of the prepayment enrollment, the exact nature and magnitude of the classes of expenditures where the plan has great latitude in allocating costs, and the differences in use of services by each group.

Regular Evaluation of Medicaid Prepayment

The health economics literature has a great variety of analyses of prepayment, but with few exceptions very little of this work is transferable to Medicaid prepayment. Direct research on Medicaid prepayment has been limited to utilization analyses in small-scale projects. It has not been designed to represent either a full evaluation of those projects or to shed light on the importance of the problems arising in large-scale programs. Neither of the two large-scale Medicaid prepayment programs now operating in New York City and California has yet produced a significant evaluation.

The implementation issues which have been detailed here are potentially serious, but no one can say with certainty exactly how serious. Determining the magnitude of their effects on the costs and quality of services produced, and comparing the results of prepayment versus fee-for-service financing of Medicaid can only be achieved through regular, well-designed evaluations of the operation of large-scale programs. Given the differences in the incentives acting on both consumer and provider in Medicaid prepayment, the significance of the impact of those differences in a variety of settings needs to be highlighted. This paper has only pointed out a number of the areas which have to be explored in such an evaluation because the information to do more than that simply is not available. The cry for meaningful evaluations of new social programs, and the dangers of neglecting that research have echoed repeatedly in the literature, conferences, and meetings with funding agencies. These calls have not been heeded, with the latest indicator being Congress's failure to fund the mandatory evaluation

of prepayment called for in the recent HMO legislation. As matters now stand, Medicaid prepayment has a potential for providing another outstanding case study in the consequences of neglecting evaluation.

Conclusion

The pilot prepayment programs now operating are providing useful information on the effects of prepayment on the medically indigent in controlled settings. However, in considering the pros and cons of expanding from a pilot to full-scale operation, the pilots provide only limited information on many major implementation issues. Several of the pilots have been able to guarantee enrollment for one year or longer, so they have not had to deal with the problems of high turnover due to involuntary disenrollment when eligibility changes. The same factor limits the value of the cost and utilization data obtained under the demonstration. If one half of the population turns over during the year, the outreach, enrollment, and education costs will be significantly increased and the utilization patterns are quite likely to shift significantly. Finally, the strain on the local agency to monitoring quality of care in a dozen widely differing groups is much greater than a simple linear extrapolation of that involved in monitoring only one.

Neither of the two large-scale Medicaid prepayment programs now operating has supplied definitive answers on whether these issues will eliminate the advantage of prepayment over fee for service medical care. While a formal evaluation is still forthcoming, it is unlikely that either program is operating as expected. The exclusion of hospital costs from the old New York City program with HIP makes it an unfair test of the concept, and a comprehensive package is only now being implemented on a demonstration basis. The California program is too young, is not yet collecting the information required for a meaningful capitation rate, and has not effectively monitored quality of care, although that may improve in the next year.

The debate over the relative advantages of prepayment and fee-for-service care for regular enrollees has raged for decades. The issues in evaluating large-scale prepayment of Medicaid are

similar enough in their complexity that they will need similar time to resolve. Yet, Medicaid prepayment is different enough that the information on regular enrollees is unlikely to contribute much in determining the value of prepayment as a policy for the poor.

One question which can be settled in the short term, however, is whether or not prepayment is a more effective approach to *cost* control in the Medicaid program than a well-designed utilization-review program. The bulk of the savings realized from existing prepaid plans come through lower hospital use. The explanation for the lower use has not been isolated yet and could be due to a number of factors: less access to hospital beds, successful preventive techniques, better management of hospital stays, etc. If management is the key, conceptually, there is no reason why similar controls could not be applied in fee-for-service programs. Recent moves by Blue Cross, Medicaid, and Medicare show that the dominant financers of institutional care recognize this and are moving to institute them. Utilization review obviously has its own implementation issues, which cannot be discussed here, but during the next few years, it should be possible to test the relative effectiveness of both techniques, prepayment and utilization review, as cost-control techniques.

Given the success of the medical foundations in adopting such controls and the experience of the Medi-Cal program in California, it would not be surprising to find that the hospital experience of prepaid plans begins approaching that of the fee-for-service providers. To date, the prepaid plans have been able to take advantage of the lax management of hospital care in the fee-for-service care. The competitive edge in costs may be disappearing soon, and if it does, prepayment will be at a major turning point in its development in this country. However, it is safe to assume that in many circumstances, implementation problems will make utilization review much less effective than prepayment as an approach to cost control. For the present, both options need to be explored to become more familiar with which of them is more effective under a variety of circumstances.

Each technique must be tried with a full awareness of the responsibilities of all parties, particularly the public sector. Often advocates of prepayment give the impression that all that is necessary to establish an HMO is to assemble the staff, facilities,

enrolled population, and dollars. Given these preconditions, the "hidden hand" of economic incentives will guide the operation of the program in the desired way. This simply is not so. To date there has been little public discussion of the taxing management skills required to administer a prepaid group practice, particularly once it decentralizes into a multiple concern, and of the demands on the public sector in controlling it. With the significant funding for HMO development passed by this Congress, it is time that these issues be aired more thoroughly. Nothing could be more catastrophic for the future of prepaid medical care in this country than the new practices funded by that legislation rushing into operation blind to the experiences of the existing groups. Medicaid and Medicare prepayment will be financial cornerstones of many of these new HMOs. We hope that they and the local agencies responsible for regulating them will have the benefit of the experiences of New York City and the other existing prepayment plans which only so recently were at the same stage of development, but which have learned some lessons worth passing on.

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Ethical and Existential Developments in Contemporaneous American Medicine: Their Implications for Culture and Society

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Contemporaneous Western medicine is often depicted as a vast body of scientific knowledge, technical skills, medicaments, and machinery wielded by physician-led teams of hospital-based professionals and paraprofessionals, garbed in uniforms of starched white, surgical green, and auxiliary pink or blue. Underlying this image is the conception that medicine is shaped primarily by scientific and technological advances, and that its major impetus derives from a highly organized collective effort vigorously to preserve life, by attaining a progressive mastery over illness and preventable death.

However commonplace and accurate this notion of modern medicine may be in some regards, it is distorted and obsolete in others. It does not take into account a new and important set of developments in present-day medicine that seems to be gaining momentum. Over the course of the past fifteen years, in a number of European and American societies, concerned interest in ethical and existential issues related to biomedical progress and to the delivery of medical care has become both more manifest and legitimate in medical circles and in other professional and organized lay groups as well. This is a phenomenon that merits sociological attention for it suggests that a serious re-examination of certain basic cultural assumptions on which modern medicine is premised may be taking place.

This paper will identify some of the forms in which these moral and metaphysical problems are currently being raised in the medical sector of American (U.S.A.) society. It will also essay an interpretive analysis of the broader socio-cultural implications of the more general re-evaluative process that I believe is occurring in this fashion.

> Recent advances in biology and medicine make it increasingly clear that we are rapidly acquiring greater powers to modify and perhaps control the capacities and activities of men by direct intervention into and manipulation of their bodies and minds. Certain means are already in use or at hand—for example, organ transplantation, pre-