Physician Behavior in a Medicaid Capitated Managed Care System: An Examination of the Health Plan of San Mateo

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PHYSICIAN BEHAVIOR IN A MEDICAID CAPITATED MANAGED CARE SYSTEM

An Examination of the Health Plan of San Mateo

by

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Abstract

The rapidly rising rate of expenditures on public health services has engendered a search for more cost-effective means of delivering health care. Capitated managed care is a common model employed by Medicaid experimentation projects in an attempt to reduce medical expenditures. This paper explores the evolution of the Medicaid program from a historical perspective in order to understand why the strategies employed today have been developed. Capitated managed care programs rely on the central role of the primary care physician to control health care utilization. This paper explores the determinants of physician behavior and the theoretical basis of the efficacy of managed care. A survey of 65 physicians in the Health Plan of San Mateo, a Medicaid demonstration project, is presented and the results are explored with reference to their policy implications. Most physicians have noted little change in their practice behavior as well as strong feelings regarding the role of case manager and their ability to deliver health care to their patients under the new system. Finally, the ethical challenges of capitated prospective payment are explored and policy options discussed.
DEDICATION

This work is dedicated to my parents, Jeremiah Brown and Grace Freeman, who have given me the motivation to reach for the highest goals and to never become discouraged. I also dedicate this to Kelly, whose unselfish support I will always cherish.
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INTRODUCTION
The rapidly rising rate of expenditures on public medical services has been the single most important driving factor in the search to find more cost-effective means of delivering health care. From the perspective of state governments, this increase has resulted in a steady decline in the availability of resources to confront other social problems. From 1972 to 1982, Medicaid expenditures increased at an annual rate of 16.9%, while state revenues increased at an 11.4% annual rate (Gornick 1985). Thus, the prominent issue facing health economists, health planners and administrators throughout the 1980's has been cost-containment as a policy strategy.

The focus of cost-containment in the 1980's has shifted away from the regulatory strategies of the 1970's and has embraced the tactics of capitation and competition. The Medicaid program has experimented with a managed care system of health care delivery in which patients have restricted freedom to choose their doctor and physicians are given incentives to provide medical care at a lower cost. Managed care relies on the central allocative role of the primary care physician as a gatekeeper to rest of the medical care system. Capitation is a payment mechanism in which providers receive a set fee per month, per patient in their practice. In theory, capitation provides an incentive for providers to keep patients well and provide only necessary services.

The Health Plan of San Mateo is a Medicaid pilot program implementing capitation and managed care. It is one of many pilot programs which has been initiated in order to evaluate alternatives to the present system of delivering health care (Hurley and Freund 1988). The intent is to develop delivery systems which provide health care services in a more cost-effective manner.

In this paper, will investigate the following questions:
o Does the Health Plan of San Mateo produce the changes in physician attitude and behavior which are necessary for the success of a capitated managed care system?

o Do the incentives of a capitated Medicaid system fulfill the County’s ethical obligations to Medicaid beneficiaries?

o Does the Health Plan of San Mateo fulfill the original goals of the Medicaid program?

In order to answer these questions, this paper first examines the history of the Medicaid program and its evolution to its present form. The theoretical basis of managed care is examined as well as research into the determinants of physician behavior. Next, the research instrument, a survey of physicians in the Health Plan of San Mateo (HPSM), is presented, followed by a discussion of the results. The survey of sixty-five physicians was implemented in order to assess physician attitudes and behavioral changes occurring since the HPSM began. Next, the survey results and policy implications will be examined with reference to the research questions. Finally, the issues surrounding the ethics of prospective payment will be discussed.
CHAPTER I

HISTORICAL BACKGROUND OF THE MEDICAID PROGRAM
General Description

Medicaid, a health care program organized on the federal, state and local level, was designed to deliver health care services to specific groups of the poor. Enacted into law July 30, 1965 as Title XIX of Social Security Act, Medicaid allows states to set eligibility criteria and benefits under Federal guidelines. Consequently, there is considerable variation across the states in terms of who is eligible and what services they may obtain.

Individuals are categorically eligible if they qualify to receive cash payments under the Social Security Act: Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI) program for the aged, blind and disabled. States may also provide Medicaid services to the "medically needy", those who do not meet the income requirements of cash assistance, but whose income and assets meet the medically needy requirements or those who spend down to this level because of lack of health insurance (Gornick, et. al. 1985).

States are required to offer certain basic services such as hospital inpatient and outpatient care, skilled nursing facility care (SNF) for individuals age 21 and over, home health care for individuals eligible for SNF services, physicians' services, family planning, rural health clinic services and early and periodic screening, diagnosis and treatment for individuals under 21. In addition, States may provide other services including drugs, eyeglasses, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21 years of age, physical therapy, and dental care (Gornick et. al. 1985).

Medicaid is jointly financed by the States and the Federal government. In 1985, the Federal financial contribution varied between 50-78%, depending upon the State’s per capita income (Gornick et. al. 1985).
In 1985, the U.S. population was estimated at 238 million persons, of whom 21.4 million (or 9%) were eligible for Medicaid. This population is primarily composed of children and their mothers who are eligible for Aid for Families with Dependent Children (AFDC). Although these individuals make up approximately 70 percent of the Medicaid population, they are responsible for only 25 percent of Medicaid expenditures (Gornick et. al. 1985).

Individuals eligible for the Supplemental Security Income (SSI) program of Social Security make up less than 30 percent of Medicaid population. However, they account for more than 70 percent of Medicaid outlays. To be eligible for SSI, a person must meet both income and categorical requirements. The category of aged requires that an individual be 65 or older; the blindness and disability status are determined according to Social Security disability criteria. A major portion of Medicaid expenditures for this group provides nursing home services. This very expensive form of care exceeds $20,000 per year per person. In 1984, Medicaid paid for 43 percent of all nursing home expenditures in the U.S. (Gornick, et. al. 1985).

In 1975, AFDC families were 64 percent of the Medicaid population and received 35 percent of Medicaid funds. As already noted, the percentage of AFDC eligibles rose slightly to 68 percent in 1984, but their share of Medicaid funds dropped to 25 percent (Gornick, et. al. 1985).

The Enactment of Medicaid

The primary goal of Medicaid was to provide access to health care for particular groups of poor persons (Gornick, et. al. 1985). Wilbur Cohen, the Secretary of the Department of Health, Education and Welfare under Presidents Kennedy and Johnson, was an instrumental player in the drafting and enactment of
the Medicaid and Medicare legislation. He has explained that the inclusion of Medicaid with the Medicare legislation was a way to assure opponents of compulsory national health insurance that Medicare was not an entering wedge to a national health plan (Cohen 1985b). The inclusion of Medicaid would thus assure critics that Medicaid and Medicare alone would cover everyone that was in need of health insurance coverage. Thus, a national health program would be unnecessary.

The Medicaid program grew out of then existing public assistance programs. The idea of a Medicaid type program was first entertained in 1942 (Cohen 1985b). However, it would not have passed Congress without linkage to an insurance program for the nation’s elderly.

While the issue of reimbursement of physicians is a fiercely debated topic today, alternatives to fee-for-service (FFS) reimbursement were only briefly discussed at this time. This was due to our nation’s limited experience with large-scale national health reimbursement programs. At this time, the entire health care system was built upon the FFS model. Rather than practical concerns, ideological and political issues were the dominating focus of debate between 1960-65. Moreover, anything other than FFS and freedom of choice of physician would have exacerbated the already strong American Medical Association political opposition. Therefore, little consideration was given to reimbursement alternatives and efficiency issues (Cohen 1985; Hurley and Freund 1987).

The Evolution of Medicaid

Numerous studies have demonstrated that the Medicaid program as originally designed was very successful in improving access to health care (Davidson S., et. al. 1986; Hurley & Freund 1987; Gornick, et. al.1985). In 1963, before the passage of Medicaid, only 56 percent of persons from a low income family saw a physician in
a given year. However, 70 percent of persons from high income families saw a physician each year (Andersen, Lion & Anderson 1976). As early as 1970, that figure had risen to 65 percent for poor persons while the figure for the high income families remained essentially the same. Medicaid was largely responsible for this change (Gornick, et.al. 1985). Today, the differential use of services by income has virtually been erased.

This issue can also be examined from the perspective of physician visits per year. In 1963, persons under the poverty level had an average of 4.4 visits per year while high income persons averaged 4.6 visits per year. In 1970, the figures stood at 4.9 visits per year for the poor, while visits for persons from high income families dropped to 3.6. In 1980, low income persons made 4.6 visits per year while upper income persons saw a physician 3.9 times per year (Gornick). Poor persons have an increased need for physician services due to lower health status (Aday, Anderson and Fleming 1980). Therefore, controlling for health status, the poor receive somewhat less care than higher income groups (Gornick et. al. 1985).

These improvements came at a much higher cost than expected. The slow economic growth and persistent inflation of the 1970's led to a shift from redistributive to regulatory policies in health care (Starr 1982). During a press conference in 1969, President Richard Nixon declared, "We face a massive crisis in this area [Medicaid and Medicare]. Unless action is taken within the next two or three years ... we will have a breakdown in our medical system" (Starr 1982). In the seven years preceding Medicaid and Medicare, national health expenditures increased at a rate of 3.2 percent a year; in the five years following this legislation, expenditures increased at an annual rate of 7.9 percent. It was becoming apparent that business, government and the public would not allow this rate of growth to be sustained indefinitely. Seventy-five percent of families in 1970 agreed with the statement, "There is a crisis in health care in the United
States." Furthermore, in January 1970, the editors of Fortune magazine wrote a scathing critique of American medicine stating:

Much of U.S. medical care, particularly the everyday business of preventing and treating routine illnesses, is inferior in quality, wastefully dispensed, and inequitably financed ... Whether poor or not, most Americans are badly served by the obsolete, overstrained medical system that has grown up around them helter-skelter ... the time has come for radical change (Starr 1982).

These forces provided powerful fuel for changes. The result was that a program whose goal was to redistribute wealth from the more well to do toward the poor changed its orientation to focus on strategies of controlling costs.

It is ironic that despite these forces, health care expenditures in 1980 were $230 billion, up $69 billion from 1970, rising from 7.2 percent to 9.4 percent of GNP. But the seventies were important for setting into motion the forces for reform which persist today. The current experimentation in systems of financing health care delivery can trace its roots to calls for change which originated in the seventies.

In his book, The Social Transformation of American Medicine, Paul Starr gives an insightful analysis of the political, economic and sociological forces which culminated in our nation's response to these rising costs. Much of what follows is derived from his sociological study.

Our nation's response to rising medical costs was not derived solely from economic concerns. There was also a declining faith in the idealism and a loss of confidence in medicine. This view was most forcefully expressed in 1976 by Ivan Illich in Medical Nemesis: The Expropriation of Health. In his book, Illich argues that Americans would be better off if they freed themselves of the domination imposed by the modern medical model. Moreover, concern was raised about the increasingly powerful role that doctors and hospitals had attained in society. The women's movement played a large role in bringing these issues to public attention.
These concerns led to a call for a greater protection of patients' rights (Starr 1982).

For first time in the twentieth century, physicians faced a challenge to their political influence on economic power and cultural authority. According to Starr, two major factors led to the physicians' fall from public favor: (1) emerging contradictions of accommodation to physician desires and (2) generalization of rights.

The contradictions of accommodation

The concessions that the American Medical Association secured in the passage of Medicare and Medicaid left the government with no way of controlling costs. Reimbursement was open-ended -- the more services provided, the greater the expenditures. As costs escalated, the government developed an interest in decreasing costs and provider influence. Also, as insurance premiums rose, employers also began to distinguish their interests from those of the health care industry. Moreover, many people were now doubting the value of high expenditures.

Data were published which stated that Americans had high rates of surgery with little clear additional benefit (Starr 1982). It was assumed that this abuse was occurring because patients were insulated from the costs, hospitals were reimbursed based on whatever they charged, and the costs of procedures performed in the hospital were much higher than when performed in outpatient facilities.

This lack of restraint on costs was the result of a history of accommodating physicians, hospitals and insurance companies. Ironically, the costs of Medicaid actually weakened public medical institutions. This occurred because high medical care costs drained local government budgets. Poor persons seeking care could go to any hospital, resulting in municipal institutions having fewer funds for dealing with uninsured patients.

This economic pressure on hospitals resulted in significant cost shifting.
Prices were raised for services for paying customers so that the costs of uninsured patients would be covered. Private insurance companies called for an end to cost-shifting, desiring a more global response to these problems, such as community health plans or state regulation of hospital charges. Employers desired to bring a halt to rapidly rising health insurance premiums.

Thus, the insurance industry, employers and governments were all demanding reform.

The generalization of rights

The second factor leading to cost-control strategies in health care was the generalization of rights. In the 70's, the idea of health care as a right became more prevalent. Because society does not have unlimited resources, this view required that cost control be built into the system. Increased focus on patient rights also resulted in limiting physician authority. The courts began to view the physician-patient relationship as a partnership in decision instead of a MD monopoly. A patient bill of rights, drafted by the American Hospital Association in 1972, included the important tenet that a patient must give informed consent for any procedure performed by a physician (Starr 1982).

Moreover, the women's movement espoused a strong distrust of professional domination. Increasing numbers of women entering the profession demanded changes in practice techniques and attitudes. By the end of the 1970's, Americans expressed a confidence in their own personal doctor, but distrust of physicians as a class (Starr 1982).

Strategies for Cost Control

The first serious attempts at cost control began in the Nixon Administration. On June 3, 1971, John G. Veneman, undersecretary of Dept Health Education and
Welfare (HEW) stated, "In the past, decisions on health care delivery were largely professional ones. Now the decisions will be largely political" (Starr 1982).

The Nixon Administration adopted the health maintenance organization (HMO) strategy as a way to prepay for Medicare and Medicaid. It was hoped that legislative incentives would stimulate the development of prepaid plans. While prepaid group practice was originally associated with the cooperative movement and was dismissed as utopian, it was now embraced by conservative cost-minded critics who adopted it as "a more efficient form of management" (Starr 1982). It was hoped that prepaid health care would end the "illogical incentive" for physicians and hospitals to profit from illness rather than health. Thus, what was heretofore labelled socialized medicine was now the standard of corporate reform.

While the administration waited for the growth in HMOs, regulatory strategies were implemented. The Department of HEW was given authority to appoint "program review teams" of physician's, other health professionals and consumers that would deny payment for unnecessary Medicare services. However, because of AMA opposition, this plan was converted to the Peer Standards Review Organizations (PSRO) plan developed by Sen. Wallace Bennett of Utah. The PSRO plan employed only physicians in the review of medical practices. Bennett stated that he feared that the Nixon bill gave HEW too much power and that review should be left to the domain of physicians alone. Ralph Nader's group denounced the plan which he said "left the fox guarding the henhouse" (Starr 1982). It is important to note that this policy did not attempt to regulate physician office practice. It was hoped that physician discretion within hospitals could be controlled by providing hospitals with the incentive to construct regulations so that its charges for services would not be denied (Starr 1982).

Nixon's most direct attempt at cost control was the imposition of a general price freeze in 1971. Other attempts included funding to increase the supply of
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physicians, regulation of the construction of health care facilities and the
development of the powerless Health Service Agencies whose task was to evaluate
proposals for new projects and develop long range plans. Overall, these strategies
represented an attempt to socialize and control medical costs. However, little
real power was provided to improve efficiency.

Stagflation in the middle 1970's

The severe economic recession of 1974-75, accompanied by inflation, arrested
initiatives to expand medical care. The energy crisis led to an economic slowdown
which brought about a backlash against the welfare state. This brought an end to
the U.S. postwar growth in entitlement programs.

Inflationary forces were particularly strong in health care. The price
controls which were first imposed on the economy in 1971 were left on the health
industry for a year longer than the rest of the economy. When these controls were
lifted in 1974, health care caught up with a one year 12.1 percent rate of
inflation.

In retrospect, it is clear that the Nixon HMO plan was underwritten in a
self-destructive way. High requirements were imposed on the services that HMOs
were to provide and subsidies were not high enough to significantly stimulate the
industry. Furthermore, HMOs take years to develop. Starting an HMO requires
capital and trained managers that were not yet present. Moreover, HMOs were
competing in an environment where hospitals and physicians had little interest in
seeing them succeed. Thus the growth in HMOs was not fast enough to produce the
revolutionary reform in the health care industry which Nixon had desired.

President Ford's first address to Congress called for National Health
Insurance to address these problems. However, in 1976, he withdrew the plan saying
that it would worsen inflation. Meanwhile, it was clear that the regulatory
strategies were not working. In 1977, Medicare and Medicaid outlays were twice what they were just two years earlier. Little progress was made as Congress and HEW were embroiled in a meshwork of complex regulations, trying to refine PSRO codes and HMO policies. Overall, under President Ford, the Republican president and Democratic Congress made little progress toward solving many of the nation's social and economic problems.

The mid-70's were also characterized by critics who questioned whether medical care made any difference in the overall health of society. Politically, concerns of distributive justice are morally compelling only if there is a public sense that what is being distributed is valuable. Thus, the focus continued to turn away from bringing medicine to the masses and continued to concentrate attention on cost-control.

The late 1970's - pessimism about government

In 1976, Jimmy Carter was elected to the presidency as an outsider in order to change the Washington establishment and bring in new ideas. However, as an outsider, President Carter had difficulty getting support from his own party. Furthermore, as inflation became an increasing concern, the Democratic leadership refused to consider any further liberal initiatives.

In 1977, hospital charges rose at a rate of 15.6 percent while inflation was at a 6% annual rate. President Carter's first legislative attempt at cost-control was a flat cap on hospital charges limited to 1.5 times growth in CPI (consumer price index). However, the idea died in Congress because of massive lobbying by hospital industry. A second attempt to control hospital price increases died in 1979 in a fight that was led by the anti-regulatory forces in Congress and the hospital lobby (Starr 1982).

In 1976, the HMO program finally began to pick up momentum when the stringent
requirements were reduced. Data began emerging in 1977 suggesting that HMOs saved money by having fewer hospital days per beneficiary. Consequently, the HMO regulations were again amended in 1978 to increase HMO funding. The numbers of HMOs were growing, but in mid-1979 the 219 HMOs were far fewer than the 1700 which the Nixon administration had predicted (Starr 1982).

By the end of the 1970's, it was clear that access to health care was no longer a prime concern. The redistributive and regulatory reforms of 1960's and 1970's had greatly expanded the boundaries of the political process in health care. Government now carried a large share of the financial burden. However, despite all of this, health care expenditures were no more under control than they were in 1969.

The end of the 1970's ushered in a conservatism which desired to reverse this trend by throwing back the boundaries of political involvement in health care. The public perceived that government had become overburdened and ungovernable. Conservatives argued that the requirements of politics conflicted with demands of efficiency. This philosophy stood firmly upon the belief that government creates a new class with interests more in government than in providing services. The objective of this new conservatism was to return tax dollars back to the private sector and encourage competition to provide services.

Public discontent has risen to a general antipathy to government. The conservatives held before the public's eyes the simple panacea: the problems in health care in America could be cured only by relying on competition and incentives. These views led to an acceleration toward a new system of corporate medical enterprise. As the nation entered the 1980's, a search was initiated by government and employers for control by over growth of medical expenditures by competitive strategies. The sovereignty of the medical profession, which previously was able to restrict competition, limit regulation and define and interpret
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standards that govern medical work, was now ending (Starr 1982).

New Thinking

With the advent of the 1980's, the Medicaid program suffered from increasing criticism. The Reagan Administration made Medicaid the prime target for the reduction of medical expenditures. Very early on, it was apparent that Medicaid, not Medicare, was to be the recipient of major reductions (Inglehart 1983a).

Medicaid was burdened with the following problems:

- declining physician participation because of low fees, long payment delays and excessive paperwork (Hurley 1986)
- patient behavior criticized for excessive "doctor shopping", self-referral and inappropriate use of emergency room services (Hurley & Freund 1987)
- excessive rates of hospitalization both in admissions and inpatient days per 1,000 persons (Hurley 1986)

Despite this political climate, Medicaid as a program has had significant support on Capitol Hill. However, in 1981, the Reagan Administration was able to get passed an agenda which relied on a series of severe cuts in eligibility and benefits (Inglehart 1983b; Inglehart 1985). There were clear health consequences to individuals who were terminated from the Medicaid program. A study published in 1984 demonstrated a clear reduction in health status (Lurie 1984). This often resulted in further strain on the health care system as patients presented in emergency rooms with costly, far advanced conditions. As early as 1983, Congressional supporters would not allow further reductions in the scope of the Medicaid program. Senator Robert Dole (R-Kans.), chairman of Sen. Finance Comm. stated, "In Medicaid, there do not appear to be many major opportunities for cost savings" (Inglehart 1983a). When Congress was faced with the choice of making reductions in services or making more fundamental changes in the system, the new philosophy made this choice clear.
This philosophy states that purchasers of care must explore ways to alter patterns of service delivery and that competition provides a promising strategy to achieve these alterations (Hurley & Freund 1987). Medicaid was structured originally to mimic the private sector and not interfere with AMA concerns about infringement upon the physicians ability to practice medicine (Cohen 1985b). This arrangement is blamed for most of the problems with open-ended health care costs.

This new thinking turned to alternative delivery systems (ADS) which have been proven to be cost-effective. Even Willie Brown, the liberal democratic speaker of the California Assembly, wrote to his constituents:

Medi-Cal providers and the State Legislature must acknowledge that at present we no longer have sufficient resources to carry out the grand philosophical ideal which we so proudly enunciated in the mid and late 1960’s [that mainstream medicine would be available to every citizen] (Inglehart 1983a).

The strategy for change

Prior to 1981, Section 1115 of Social Security Act provided for the granting of waivers which would lower requirements of the Medicaid and Medicare programs. This allowed HCFA to relax or waive state Medicaid requirements such as eligibility definitions, consistency of coverage state wide, amount, duration and scope of services. Waivers would allow HCFA to fund and rigorously evaluate alternatives to the current organization and financing of services. The intent was to provide for an orderly, deliberate, objective process of research. However, objectivity was hard to maintain in 1980 when there were massive pressures for reform (Hurley and Freund 1987).

The Omnibus Reconciliation Act (OBRA) of 1981 introduced a new form of "programmatic waivers" in Section 1915. The states could now undertake a wide variety of experiments to reduce program costs. The key provisions of this legislation include: increased flexibility in contracting with HMOs and other
prepaid health plans; permission to limit patient freedom of choice and to use various utilization control devices; and the ability to offer clients incentives to join designated or selected provider organizations (Hurley and Freund 1987). Furthermore, the evaluation requirements and criteria were made far less extensive.

In 1982, HCFA solicited bids from states to fund a set of projects in which managed care delivery systems would be tried. Funding for these programs was made increasingly available. Over sixty managed care demonstration projects were implemented from 1981-1986.

Historically, the Medicaid program has evolved through a series of periods in which priorities were modified and new strategies were undertaken. The consistent theme throughout the seventies and eighties has been cost-containment. It has been shown that while the HMO strategy held promise for reducing costs, the expansion in HMOs which was predicted did not occur due to legislative requirements and the lack of sufficient numbers of properly trained personnel. Flat caps on spending held only ephemeral benefits because once the caps were lifted, the inflation rates increased dramatically to recoup past losses. Simply reducing the funds allocated to Medicaid was unsuccessful because this resulted in deferring medical services until the conditions had progressed to the point of requiring emergency services, which were much more costly. Currently, the managed care strategy has emerged as a result of allowing states to experiment with alternative delivery systems. In the next chapter, the theoretical basis of why managed care should provide services for lower costs will be explored. Additionally, the various models of managed care systems which have been developed will be studied.
CHAPTER II

THE THEORETICAL BASIS OF MANAGED CARE
Cost Control

Managed care as a cost control strategy relies on the pivotal role of the primary care physician (PCP) in allocation of health care resources (Hurley & Freund 1988). The idea of one central case manager responsible for coordinating the entire package of health care services received by a patient is not new to the 1980's. In the U.S., case management has its roots in rehabilitation-based models of case management used in the Worker's Compensation program since the 1940's (Henderson 1988). What is new, however, is the use of case management as a tool for cost control.

Case management was first discussed at the Federal level in 1960's. At this time, case management was not viewed as means for controlling clients but rather to help clients overcome federal bureaucracy thus maximizing their access to federal funds (Spitz & Abramson 1987). The focus of case management changed in 1981 with passage of the OBRA which allows states to "implement a case management system ... which restricts the provider from or through whom a recipient can receive primary care" (Spitz & Abramson 1987). As part of this legislation, requirements prohibited case management from "substantially impair[ing] access to services of adequate quality" (U.S. Code of Federal Regulations, Title 42, Section 431.55 (c)). In addition, states would have to demonstrate that the program was "cost effective" (U.S. Code of Federal Regulations, Title 42, Section 431.55 (b) (1)). Thus, case management had made the public policy transition from a strategy of coordinating benefits to one which required demonstrable cost-effectiveness without "substantially impairing access to services of adequate quality" (Spitz and Abramson 1987).
Case management is designed to correct problems with the behavior of Medicaid beneficiaries, as well as the behavior of physicians. The Health Care Financing Administration has a goal of reducing unnecessarily high rates of use of certain services (Hurley 1986b). These services include emergency room use for nonemergency care, high rates of self-referral to specialists and "doctor shopping", the sporadic switching of providers with no one provider being able to employ a long term approach to health. Thus, the first aim of case management is to create a more rational use of health care resources.

However, a major factor in beneficiary behavior is the fact that it is often difficult for Medicaid beneficiaries to locate a primary care provider. A decline in the level of participation of physicians in the Medicaid program was identified as early as 1974 (Davidson). More recently, a significant decline has been identified in the period from 1978 to 1983 (Perloff, Kletke & Neckerman 1987; Perloff, Neckerman and Kletke 1986). Reducing the delays in payment, the amount of paperwork and the administrative burdens were identified as reforms that would improve physician participation. Moreover, it is assumed that physicians will spend more time considering the cost implications of various treatment options when they are given the financial incentive to do so.

Under case management, the primary care provider becomes the key to cost-effective behavior. The assumption is that utilization will be better coordinated and made more efficient by limiting an eligible person's access to care to a single point of entry. The primary care provider will deliver most of this person's services and authorize all others (Hurley & Freund 1987).

The elements key to case management as an instrument of cost control are as follows:

1) limitation on free choice of provider
2) an attempt to modify patient utilization patterns through coordinating service delivery
3) financial incentives and risk sharing to alter physician behavior

These elements are grounded in assumptions largely from research on prepaid health plans:

1) prepaid capitated rates for comprehensive services create powerful incentives for providers to use resources judiciously
2) HMO studies have shown decreased use of hospital services, the most expensive form of care (Luft 1981; Siu, et. al. 1988)

As a gatekeeper, it is the responsibility of the physician to (1) coordinate and ration services, (2) manage entry and access to medical care system by authorization and monitoring all other care to his patients, and (3) develop decision making strategies that emphasize the rationing function (Hurley & Freund 1987).

It is apparent from this description that a case manager has responsibilities in opposite directions. It is the case manager’s responsibility to maximize his patient's benefit from the resources available; it is also his responsibility to ration those resources. In order for a case manager to have any incentive to ration care, it is necessary that the financial risk of providing services be shared between the provider and the purchaser of medical care. Prepayment of medical care is the most straightforward way of accomplishing this shared responsibility. However, it is clear that this arrangement poses important ethical questions. These issues will be discussed in Chapter VI.

Problems with Managed Care

A 1986 National Governors’ Association survey of Medicaid directors complained that "case management lack a precise conceptual or operational definition" (Spitz and Abramson 1987). Moreover, a survey of 91 HMO plans published in August 1988
indicates that even physicians in HMO's may be confused about the role of a case manager (Traska 1988). Without a precise operational definition, case management is not a system of integrated care but is rather a personalized process. It is a process in which it is not clear to many people what a physician is responsible for beyond that which he would ordinarily do as a primary care physician. If physicians cannot determine what the substance of the case management program is, how can Medicaid programs evaluate when proper management occurs and when it does not?

Even if case management were non-existent, the fact that the patient is "locked in" to one provider would be expected to reduce costs by reducing unnecessary specialist visits or emergency room visits. Thus, cost reductions would occur without any change in physician behavior (Spitz & Abramson 1987). This is significant because the current measure of success seems to be focused only on reduction of cost.

Additionally, although it might appear that prepaid managed care would reduce state administrative expenditures, this is not the case (Anderson & Fox 1987). Sophisticated monitoring programs as well as quality assurance protocols must be developed and implemented. Moreover, new staff with greater experience in financing health care are required. Thus, reduction of administrative cost should not be a reason for implementing prepaid managed care.

Case management programs have not explicitly addressed the problem that a relatively few number of patients account for a large share of costs. It may be more useful to develop strategies which look at high cost users and low cost users separately (Berenson 1985).

The survey instrument to be described in Chapter VI attempts to measure physician perception of how the managed care program has changed their behavior with respect to Medicaid patients. Physician attitudes are important to the
success of a true case management program. In light of the fact that the Health Plan of San Mateo is currently over budget for specialty referrals, research into how physicians make treatment decisions improves our understanding of the effects of a case management program.

The case management system presents new conflicts of interest for physicians and it is not clear whether the caregiver can act as an advocate for the patient, as well as an agent of the health care system (Kane 1988). These issues and their ethical implications will be explored more fully in Chapters IV and VI.

Another aspect of case management concerns the ability of a physician to perform these responsibilities. In order for a physician to be an effective case manager, he must be able to think in terms of cost-effectiveness when considering referral services. Most physicians did not receive this training in medical school and this subject is overlooked in many medical school curricula today (Jacobs & Mott 1987). Complicating this dilemma, the lack of available information about the relative efficiencies of medical practices makes the job of case manager difficult even if physician is trained in this area. The case manager should be able to have reliable data about specialists' clinical effectiveness and efficiency (Eisenberg 1985a). Currently, this information often is not available. Lastly, this evaluative process can be very time-consuming and the level of remuneration is not very high.

In summary, the role of the case manager is the newest strategy at cost control. This is a strategy which focuses its attention upon the ultimate provider of services rather than imposing regulations from above. The incentive for rationing behavior is provided by placing the case manager financially at risk for the delivery of health care. However, currently the role is poorly defined and moreover, physicians may not have the abilities or the data available to them to be effective case managers. In the next chapter, we will examine the short history
of managed care in Medicaid from a practical perspective. An overview of the structural features of the experimental projects tried thus far will be presented, as well as analysis explaining the failure of two prepaid case management programs. Additionally, a classification of the Health Plan of San Mateo will be made within this conceptual framework.
CHAPTER III

MANAGED CARE IN MEDICAID
In the period between 1981 and 1986, 60 managed Medicaid programs had been developed and put into operation. All programs have in common the characteristic of limiting an individual's point of entry into the system to one point of entry. Hurley and Freund have identified six attributes that differentiate the programs (1988). As will be demonstrated, these attributes will affect the long run success of the program. Furthermore, after evaluating the Health Plan of San Mateo on these criteria, it will be possible to explain survey data and predict areas of success and failure.

1. type of enrollment
2. organizational approach
3. case manager participation
4. case manager service range responsibility
5. case manager payment method
6. payment arrangement for other providers

The manner in which Medicaid beneficiaries are enrolled in the health plans has varied in the experimental programs. Participation may be voluntary or mandatory. Typically, voluntary programs must offer incentives for participation. For example, in Illinois a negative incentive approach has been implemented. Medicaid beneficiaries choosing to remain in the traditional Medicaid program must pay a copayment fee for services received. A common positive incentive used is to offer beneficiaries guaranteed eligibility for Medicaid services for six months or more if they join the managed program. In this way, they can continue to receive Medicaid benefits during this period even if their income exceeds Medicaid limits during one of the months (Freund and Neuschler 1986).

Research findings regarding the success of voluntary programs may suffer from selection bias. For example, healthy individuals may choose the incentives and join the more restrictive capitated plan. Sick individuals with long standing
physician relationships may prefer to stick with the FFS plan. Mandatory programs may spend more time resolving complaints as individuals are unable to opt out of the system.

Membership in the Health Plan of San Mateo is mandatory for the County's approximately 28,000 Medicaid beneficiaries. Upon becoming eligible for Medicaid services, beneficiaries are sent information regarding choosing a physician and a list of participating providers. The beneficiaries are instructed to call in their choice or return an enclose preference sheet. If they do not make this choice, they are assigned to a physician. In January of 1989, a Health Plan of San Mateo study revealed that 39% of beneficiaries actually chose their primary care physician and 61% are assigned by the Health Plan (Operations Director's Report to Administration, January 1989).

On an organizational level, the state Medicaid agency may contract directly with case managers or the state may contracts with a risk-assuming intermediary which contracts with case managers. The intermediary has been called a Health Insuring Organization (HIO), such as the Health Plan of San Mateo, a county run HIO. In such an organization, the HIO assumes full responsibility for the provision of care. The HIO must then contract with the health care providers (hospitals, clinics, specialists, etc.). The state pays a capitated rate to the HIO which is usually 95% of what the state would have paid under FFS. From the state's perspective, this arrangement guarantees a savings for its Medicaid agency. However, the Health Insuring Organization may not have the resources available to run such a complex organization which must work under the patchwork of Federal and state regulations. Changes in Federal law in 1985 have greatly restricted the use of HIO's (Public Law 99-272 or Consolidated Omnibus Reconciliation Act of 1986). Currently, HIO's must meet the requirements established for HMOs, including maintaining at least a 25% non-Medicaid population. Additionally, disenrollment
Physician Behavior in Medicaid Managed Care

must be permitted on demand (Halfon & Newachek 1986). HIO’s currently under operation may continue, however it is expected that these requirements will make it difficult for future HIO’s to commence operation. Especially difficult will be maintaining a 25% non-Medicaid membership. In plans which are implemented, the problem of voluntary membership and the selection bias which may be introduced will affect future research.

The HIO approach has achieved cost savings in Santa Barbara County in California (Freund & Neuschler 1986). However, a plan in Monterey County, California went bankrupt due in part to a lack of adequate utilization control and a management information system (Freund and Neuschler 1986). This health plan will be explored in more detail later in this chapter.

The third feature distinguishing the managed care programs is the entity that performs the case manager function. This role may be performed by be a primary care physician, prepaid health plans or primary care organizations like health centers, clinics, etc.

The implemented programs also differ in the manner in which they pay their case manager. Five strategies have emerged: (1) fee-for-service (FFS); (2) FFS plus a case manager fee ($1.50-3 per person per month); (3) FFS with shared savings opportunities; (4) capitation with shared savings opportunities; (5) capitation (Hurley 1988).

It has been noted that providers in the FFS plus a case manager fee look at this payment as simply a pay increase that was long overdue (Hurley 1988). In this case, we would hardly expect the physicians to behave any differently. In FFS programs the case manager is not financially at risk for the costs of the care which he prescribes. In the capitated systems, the physician receives a set actuarially determined amount per patient per month which provides an incentive to keep down the costs of care. Some plans provide for shared savings. In these
systems, the case managers may receive a bonus if their referral costs are below a target figure and may be penalized if costs go beyond that figure.

The Health Plan of San Mateo employs a capitated payment scheme with shared savings for the case managers. The County is divided up into five regions. Each region has a target for hospital and referral service costs. Physicians are paid a set figure per month per patient; however, they only receive 80 percent of that amount at the beginning of each month. Twenty percent is withheld until the end of the year. If the region in which they practice goes over budget, the difference is made up from the withheld funds. If the region is below their target, they will receive their withheld funds back as well as a possible bonus.

The method of payment of other providers in implemented managed care programs may be accomplished in several different manners. These other providers may be paid according to the traditional Medicaid program. Optionally, a payment scheme may be negotiated with these providers by the HIO. Lastly, the payment of the other providers may be negotiated by the case manager. Typically, specialists are paid a rate which is discounted from their usual and customary charge and hospitals are paid on a per diem or fixed discount from charges. In the Health Plan of San Mateo, specialist and hospital payments are negotiated by the Health Plan.

In summary, the Health Plan of San Mateo is a case managed health insuring organization providing health care services only to Medicaid beneficiaries, whose membership is mandatory. Case management is limited to primary care providers whose responsibility is to provide or authorize all care for their patients. Case managers are paid a capitated rate with shared savings opportunities. Specialist in the Health Plan are paid a fee-for-service rate and hospitals are paid a per diem rate, both of which are negotiated by the Health Plan.
Two Failed Systems

In 1978, the SAFECO insurance company organized and implemented the United Healthcare Corporation, a new type of commercial health care organization designed to encourage the development of cost conscious behavior amongst primary care providers (Moore 1983). The innovative aspect of this health plan was that it required its physicians to act as gatekeepers to health care. The providers would be required to cosign for all services which were provided to their patients. An element of financial risk was added setting up an account for each patient from which all services would be paid. There were no maximum fee limits on any of the charges.

The primary care provider’s loss or gain was limited to 10 percent of his reimbursed charges. If there were funds remaining in the account at the end of the year, the physician retained 50 percent of this amount, up to 10 percent of his own charges. The physician was penalized by up to 10 percent of his charges if there was a deficit in the account.

Initially, hospitalization rates were very low, and the plan appeared to be saving money. In retrospect, it is felt that these savings were probably due to a phenomenon seen in the first year of fast growing plans rather than because of effective cost controls (Moore 1983). In 1979 and 1980, large increases in referral costs, hospitalization rates and hospital charges were seen. By 1980, it was clear that the plan was not working. A series of late efforts made in attempt to control costs were unsuccessful. In 1981, SAFECO attempted, and was unable, to find a buyer for the program. A decision was made to terminate the program in October of 1981 (Moore 1983).

The results of this experiment demonstrate that small financial incentives for physicians are not enough to change behavior in a fee-for-service system.
Moreover, the small risk only applied to a small percentage of the total patients in their practices. In this health plan, the majority of physicians had fewer than 50 SAFECO patients.

Physicians noted that their success in the program depended on the number of random very expensive illnesses which occurred in their patients, despite any changes in their behavior. Even if they practiced precisely as the plan wanted them to, one or two sick patients could wipe out any potential savings at the end of the year (Moore 1983).

In 1983, California initiated two county run Medicaid health plans, in Monterey and Santa Barbara (Hurley 1988). The two plans were structured similarly; both plans were county run, risk assuming HIO’s with mandatory membership for all Medicaid beneficiaries. Both plans limited the case managers to primary care providers who were responsible for providing and authorizing all care. Contracts with specialists and hospitals were negotiated by the HIO. However, there was a significant difference in how the case managers were paid. Case managers in the Santa Barbara plan were paid a capitated rate with shared savings opportunities. Case managers in Monterey were paid on a FFS basis with a $3.00 per patient per month fee for performing case management. The Monterey Health Initiative chose to implement a payment scheme similar to the traditional Medicaid system because of political reasons. The Monterey planners felt that this system would require little change on the part of the physicians and would increase provider participation (Aved 1987).

The Monterey Health Initiative was rushed into operation in 1982 as California aspired to be in the forefront of capitated managed care policy (Aved 1987). This plan implemented a structure very similar to the SAFECO plan which had appeared to be successful at the time that the Monterey plan was being designed. Once again, the only physician incentive to practice cost conscious medicine was a trust
account established for each physician which was credited monthly for each beneficiary in the practice. At the end of the year, all surplus accounts were pooled to pay off any deficits. Any remaining surplus would be shared amongst the case managers (Aved 1987).

Additionally, the Monterey program was lacking in the area of utilization control. The Monterey planners chose to make the system as decentralized as possible, leaving all of the decision making responsibilities regarding care in the hands of the physicians. The administration of the health plan was unable to recognize early that utilization rates were not declining because they failed to have a functional management information system until well after the plan commenced operation. To make matters worse, the Plan awarded the case managers a large bonus at the end of the first year of operation because they were using financial and utilization data which did not accurately reflect the financial status of the health plan. Twenty months after the Monterey Health Initiative commenced operation, the plan was terminated.

Many of the Monterey problems can be traced to the fact that the case managers had few incentives to reduce costs. A decentralized authorization system requires that physicians understand the need to deny inappropriate medical services for his or her patients. In Monterey, physicians were not educated about the financial and medical care consequences of operating under a fixed budget (Aved 1987). In contrast, the Santa Barbara Plan, with a capitated payment mechanism which places physicians under direct financial risk, has noted some, albeit small, savings (Freund and Neuschler 1986).

Nearly all the savings attributed to prepaid health plans is derived from a reduction in hospitalization rates (Aved 1987). Utilization rates of outpatient services do not appear to be altered (Moore 1983; Hurley and Freund 1988). In light of these facts, one must wonder whether savings can be attributed to true
co-ordination of services and better health care under case management as opposed to restricted entry into the system. The evidence suggests that capitation reimbursement for physicians provides more incentives for physicians to consider cost issues when considering hospitalization (Freund 1987). However, it is not clear that the amount of money that a physician risks in any of these systems is large enough to result in a change in specialty referral or individual practice behavior.

As previously mentioned, 20 percent of the capitation payment to case managers in the Health Plan of San Mateo is withheld until the end of the fiscal year. Return of these funds to the individual case manager depends not only on his behavior, but on the behavior of all other physicians in his region. An important question which will be explored in the discussion of the survey results is whether or not this sort of risk is an adequate incentive for physicians to fulfill the case manager's function.

Having considered the theoretical basis of managed care and the organizational structures employed in managed care systems, it is appropriate to now consider the factors involved in physician decision making. The use of financial incentives to guide physician practice patterns is based upon assumptions about physician behavior. In the next chapter, research into the influences on physician decision making will be presented and considered with respect to a behavioral model of the case manager. The conflicting roles that a capitated case managed system imposes upon the physician will be explored.
CHAPTER IV

THE DETERMINANTS AND POLICY IMPLICATIONS OF PHYSICIAN BEHAVIOR
As discussed in Chapter I, the enactment of Medicaid legislation in 1965 was part of a compromise to ensure the passage of Medicare legislation. The goal of these programs was to make medical services available to those who needed, but could not otherwise afford them and to make those services available in the "mainstream of American medicine" (Davidson 1982).

Research throughout the 1970's demonstrated that large numbers of U.S. physicians were dissatisfied with the program and were limiting their participation (Davidson 1982; 1974). The issues surrounding decisions to reduce participation in Medicaid may help predict how physicians will respond to modifications to the Medicaid program, such as the system employed by the Health Plan of San Mateo. Furthermore, physicians' motivations in health care decisions are important for the following compelling reason: although physicians' professional fees represent only one fifth of health care expenditures in this country, their decisions affect how ninety percent of total expenditures are used (Eisenberg 1985b).

Successful implementation of policy strategies to modify physician behavior requires that the influences on physician behavior be well characterized. To this end, this chapter will explore: (a) the determinants of physician behavior; (b) the Medicaid policy implications of factors affecting physician decisions to limit Medicaid participation; and (c) a behavioral model of the case manager which integrates the various roles that a physician must play. A thorough understanding of the influences faced by physicians in their sometimes contradictory roles will provide a context in which to interpret physician survey responses and propose policy options.
Determinants of Physician Behavior

The greatest difficulty in trying to reason your way scientifically through the problems of human disease is that there are so few solid facts to reason with. It is not a science like physics or even biology, where the data have been accumulating in great mounds and the problem is to sort through them and make connections on which theory can be based. For most of this century -- by far the most productive of technology in the history of medicine -- clues have been found through analogies to known disease states in animals, sometimes only vaguely resembling the human disease in question. -- Lewis Thomas

To be sure, all physicians do not practice alike. There is evidence that physicians when confronted with the same disease signs will treat in radically different manners, with little difference in outcome (Wennberg, McPherson & Caper 1984; Chassin, et. al. 1986; Eisenberg and Nicklin 1981). This variation can be due to physician factors, such as the location of where training was received, environmental factors, such as the economic conditions under which the physician is practicing, and it can be due to the sometimes inadequate body of conclusive evidence regarding human disease. In fact, research has suggested that failure of cost-containment strategies may be due in part to a failure to recognize that physicians have different beliefs about disease and outcomes of alternative therapies (Wennberg, Barnes & Zubkoff 1982). Rather, variation is often inappropriately assumed to be deviant physician behavior. Moreover, much of healing is dependent upon the relationship between the physician and his patient. Medicine is not a perfect science. Struggling with the difficulty in reasoning from symptom to disease to treatment is part of the art that medical practice requires.

Eisenberg has suggested that physicians make their decisions based on influences from three often competing concerns:

1) self-interest
2) concern for individual patients
3) regard for the society as a whole (Eisenberg 1985b)

Individual physicians will vary as to the importance placed on each of these areas.

Self interest

Medical decision making will be influenced by the extent to which physicians wish to maximize their own benefit in the practice of medicine. This behavior manifests itself in five areas: (1) desire for income, (2) desire for a style of practice, (3) physician’s personal characteristics, (4) practice setting, and (5) standards established by clinical leadership (Eisenberg 1985b).

While some health economists suggest that the physician’s sole concern is maximizing income, most evidence suggests that physicians try to find a balance between income and other desires, such as leisure (Eisenberg 1985b). Applying basic market theory to a physician’s decision to participate in Medicaid helps elucidate the motivations involved.

In the private market, the physician is a price setter. The physician is able to receive compensation which is close to his charges from many third party insurers. If there is a large difference between what he is reimbursed and his charges, he may choose to charge the patient that difference. However, in the public market, the physician is a price taker. Medicaid reimbursement levels are often substantially below charges and the physician is unable to charge the difference to the patient. It is not uncommon for the overhead costs alone for an office visit for a Medicaid patient to be higher than the reimbursement received (Davidson 1982). From strictly a revenue maximizing point of view, it is in physician’s interest to maximize the private patients in his practice and minimize the public ones.
In a large 13 state followup study conducted in 1978 and 1983 of 814 and 791 pediatricians respectively, it was found that states which have the most generous Medicaid reimbursement levels are able to achieve higher levels of physician participation than those with lower levels of reimbursement (Perloff, Neckerman & Kletke 1986). However, Perloff also found that the predictive effect of reimbursement level was less strong in 1983, as issues regarding administrative procedures and Medicaid eligibility became more important.

Moreover, there is evidence that medicine does not operate under a standard supply and demand model. It appears that when the supply of physicians increases, physicians are able to generate increased demand, to a limited extent (Luft and Arno 1986). This would occur by relaxing the requirement criteria for treatment. If this phenomenon is occurring to a significant degree, one may ask whether physicians are treating more patients in order to maintain a target income or whether they believe that their patients are truly better off with the treatment but would have been overlooked previously because of more needy patients. A well respected study conducted by Rossiter and Wilensky showed that physicians were primarily motivated by medical rather than financial concerns (Rossiter and Wilensky 1983).

Physician decision making will also vary according to the style of practice that is desired. Because of varying values, tastes and habits, physicians will often adopt different styles of medicine in order to have a particular lifestyle outside of medicine.

The demographic characteristics of physicians also clearly affect the practice patterns that they adopt. Characteristics which have been studied include age, sex, type of training and specialty.
For example, Eisenberg and Nicklin showed that younger doctors often prescribe more ancillary tests and services, however they use shorter lengths of hospital stay than their older colleagues. In this study, it was shown that differences in doctors's ages alone could explain 5% of the variation noted in the ordering of laboratory tests and 3% of the variation in X-ray usage (Eisenberg and Nicklin 1981).

The site of practice has also been shown to be important. The impact of peer pressure on utilization and the ability to confer on cases have their strongest effects in HMO's and group practice settings. The HMO examples are well documented (Luft 1983), however it also is interesting to note that a study of university physicians revealed the fact that physicians felt that pressure from other colleagues on their staff was a significant factor in the use of diagnostic tests (Williams, et. al 1982).

Lastly, the role of clinical leadership is an important influence in physicians' self interested motivations. It appears that particulary respected individuals within a medical community can have a strong effect upon the decisions made by others. Thus, these clinical leaders can be very influential in determining the practice style of the group (Eisenberg 1985b).

The Physician as the Patient's Advocate

Literature on physicians' decision making lends strong support to the idea that physicians act and make decisions as their patients' agents and that this has a significant effect upon the decisions made (Eisenberg 1985b). Eisenberg has identified six areas of concern: (1) patient's economic well-being; (2) clinical factors; (3) patient demand; (4) defensive medicine; (5) patient characteristics; and (6) patient convenience.

Research has demonstrated that the prices that patients must pay does
have an impact on the treatment plans made by physicians. Data has shown this to be true with respect to number of ambulatory visits, prescriptions for drugs and tests prescribed (Rossiter and Wilensky 1983; Long, Cummings & Frisof 1983; Zelnio 1982; Becker 1983).

The clinical factors pertaining to the patient clearly play a significant role in decision making. Data suggest that clinical factors are the most important factors in the prescription of medications (Hoey, Eisenberg & Spitzer 1982). Moreover, clinical factors are the best predictors of physician initiated hospital visits and hospital bed use (Wilensky and Rossiter 1983; Wennberg, Barnes and Zubkoff 1982).

Clinical factors are often equivocal. There is significant variation in clinical decision making, even when the facts are known because of variation in patient response to treatment, variation in physician ability to deal with uncertainty and willingness to take risks and because of data which can give contradictory findings. However, whether the motivation is a professional ethos to provide the best care possible or to best assist their patients in hopes of building a practice by word of mouth, ultimately, clinical factors are playing an important role in the decisions which are made (Eisenberg 1985b).

Patient demand for services has also been shown to influence treatment decisions. On a macroeconomic level, Perloff's study of Medicaid participation showed that physicians practicing in areas in which more people became eligible for Medicaid raised their level of participation (Perloff, Kletke & Neckerman 1986). On an individual level, it has been shown that patient demand for a particular service does influence a physician's decision to prescribe it (Rothert, et. al. 1984).

Defensive medicine is often mentioned by physicians to be a significant
factor in their treatment plans. The extent to which physicians make clinical
decisions with legal consequences in mind is not clear. Studies conducted in
late 1970's failed to find legal considerations playing a significant role in
decision making. Eisenberg suggests that this is not a major determinant of
behavior (Eisenberg 1985b).

However, in the new environment of cost-containment, physicians will be
under increasing pressure to provide less comprehensive treatment and the
potential for poor outcomes may be higher. Several recent legal opinions have
explored the issue of responsibility for poor medical outcomes under programs
attempts to reduce medical utilization.

Wickline v. California is the first reported case to extensively address
the issue of whether a third party payor could be held liable for medical
malpractice resulting from a cost-containment program. Wickline was a patient
eligible for the California Medicaid program, known as Medi-Cal. After a
complex period of hospitalization and surgery, Ms. Wickline was discharged
earlier than her physician would have preferred because of a denial from a
Medi-Cal consultant whose authorization was required for a stay of that
length. The physician was able to have the hospital stay increased by 4 days,
instead of the 8 days which he requested. Several weeks after discharge, Ms.
Wickline underwent amputation of her right leg because of clotting and
infection which could have been prevented by the longer hospitalization stay
(Saue 1988).

In July 1986, the appellate court ruled that Medi-Cal was not liable,
reversing a lower court verdict for the plaintiff. The court found that if it
were the opinion of her physician that she should remain in the hospital for 4
additional days, then the physician should have once again made efforts to
keep her in the hospital.
The court ruled that:

the physician who complies without protest with the limitations imposed by a third party payer, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payer as the liability scapegoat when the consequences of his own determinations go sour (Wickline v. California, 1986).

However, a third party payor may be held responsible:

when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf are arbitrarily ignored or unreasonably disregarded or overridden.

The court concluded that:

While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgement.

Although Wickline was the first case to involve the conflict between an attending physician and a third party payor, the issue of whether or not one could be held liable for a bad outcome because of cost consciousness alone had been decided in an earlier case. In Pulvers v. Kaiser Foundation Health Plan, Inc., the widow and children of a deceased member of an HMO, brought suit against Kaiser and its physicians for malpractice. Their case was based on the theory that since Kaiser ran a system in which physicians were encouraged by an incentive payment plan to do fewer tests and treatment, the decedent and his family were fraudulently led to believe that they would receive "the best quality" of care (Saue 1988).

The court rejected this contention noting that such incentive plans were not only recommended by professional organizations as an effective means of reducing costs, but that they were also required by the HMO Act of 1973. They
also noted that there was no evidence that the "doctors act negligently or that they refrain from recommending whatever diagnostic procedures or treatments the accepted standards of their profession require" (Pulvers v. Kaiser, 1979).

In this environment, it is likely that physicians may be very concerned about prescribing treatments which are appropriate to the accepted medical standards regarding their patients, regardless of incentive plans. This calls into question somewhat the notion that a third party payor can significantly alter a physician’s practice behavior -- particularly in light of the fact that even if a third party payor is found to have corrupted medical judgement with cost considerations, it is unlikely the physician who holds "ultimate responsibility" would escape liability (Saue 1988).

The influence of patient characteristics in treatment plans and physician attitude has been well explored (Eisenberg 1979). Research has shown that patient characteristics such as social class, age, sex income, physical appearance and ethnic background all affect the recommendations given by physicians (Eisenberg 1979). This may also reflect a physician’s desire for particular type of practice, desire for particular income level, and the patient’s likelihood of having certain diseases.

Lastly, it has been shown that physicians will make decisions taking into account a patients convenience in actually making use of a prescribed medication or diagnostic test (Eisenberg 1985b).

The Physician’s Concerns about Social Goals

The requirements of medical decision making become even more complex when a physician takes societal considerations into account. Eisenberg suggests
that physicians may realize that services offered to one person result in there being fewer available for another person. However, the connection is too remote to have an effect in everyday clinical practice. Social concerns present a significant clash of interests as considerations of the physician for himself or for his patient often collide with collective interest (Eisenberg 1985b).

Six strategies can be employed to change physician practice patterns in order to take collective concerns into account: (1) education; (2) feedback; (3) participation; (4) administrative changes; (5) incentives; and (6) penalties.

Educational strategies alone have generally proven to be unsuccessful. Most educational programs may show some efficacy initially in changing physicians practices, however the alteration may only be short lived (Schroeder 1984). First, to be successful, the physicians must perceive a need for change. Second, long term success requires involving clinical leaders in the educational process and face-to-face contact is critical (Eisenberg 1985b). Moreover, the program must be an ongoing process of reinforcement of the behavior and personalized interactions.

Feedback as a strategy for changing behavior has often been tried in the form of statistical analyses of utilization behavior with comparison to peers. If the data is presented in the form of impersonal letters, it is often perceived as threatening and offensive (Eisenberg 1985b). Feedback is most successful when it is done by a clinical leader or respected member of the medical community in a face to face encounter. Further, it is most effective to focus on the areas of change that physicians agree should be changed (Schroeder 1984). Unfortunately, this personalized feedback is time-consuming and costly and in one study the costs actually surpassed the savings.
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(Schroeder 1984).

Participation of physicians in the reform process is helpful since the physician decision making is largely a decentralized process. When physicians are involved in the planning of protocols and cost-containment guidelines, the programs are more successful (Heyssel, Gaintner & Kues 1984; Thompson Kirz & Gold 1983).

The imposition of administrative rules that restrict the options available to clinicians is another way to modify behavior. This may be as simple as restricting drugs available in a formulary or requiring second opinions for surgery. If physicians are restricted from the rulemaking process or if they do not understand or agree with the rationale, the strategy may fail. Physicians may resist rules actively or simply substitute other services for restricted ones (Martin 1982).

Financial incentives attempt to change behavior by appealing directly to physicians' economic concerns. Success with financial incentives alone can depend on the practice environment. For example, financial incentives were unsuccessful in modifying resident physician practices (Eisenberg 1985b). In the SAFECO health plan described in chapter III, it appears that the financial incentives were not large enough to significantly change physician behavior. Even within the HMO setting, some researchers question whether the behavioral change is due to the economic incentive or to peer pressure and the cost conscious environment (Eisenberg 1985b). However, many physicians, ethicists and other health care observers fear that financial incentives are effective because of the concerns that these individuals raise concerning the potential for undertreatment (Relman 1983; 1985; Morreim 1985).

The use of penalties has been successful in altering practice patterns in several settings (Tuohy 1982; Paris, McNemara & Schwartz 1980). Penalties are
probably most effective when combined with an educational program and feedback.

**Medicaid Policy Implications of Research on Physician Decision Making**

The increasing propensity of physicians to limit their participation in the Medicaid program is an aspect of physician behavior that policy makers are currently attempting to address. Perloff’s study identified that pediatricians most likely to have increased their participation in Medicaid between 1978 and 1983 were those who: (1) had the smallest increases in personnel costs (2) practiced in neighborhoods which became poorer (or moved to poorer neighborhoods), (3) practiced in neighborhoods which had an increase in individuals eligible for Medicaid (or moved to a neighborhood with more Medicaid eligibles) and (4) practiced in states where the level of benefits covered increased (Perloff, Neckerman & Kletke 1986b). Moreover, increasing the level of Medicaid reimbursement was effective in converting physicians who were previously limited participants in Medicaid to becoming full participants (those that do not restrict patients from joining their practice). The research also suggests that covering more optional services, reducing complicated benefit limitations, and improving the slow, inadequate method of compensation for prior authorization might encourage more participation (Davidson 1982; Perloff, Kletke & Neckerman 1987).

It is apparent that this policy issue demonstrates aspects of physician behavior which appear to be motivated by self interest, concern for patients and concern for the social good.

Perloff’s findings can be compared with the levels of participation noted by physicians in the Health Plan of San Mateo responding to the survey.
Physician Behavior in Medicaid Managed Care

Forty-five percent chose to take on more patients than they had before the case managed system while 11 percent reduced the number of Medicaid patients in their practice. While benefit policies under both programs are the same, two important changes can be noted: (1) The Medicaid population in San Mateo County increased by 28 percent from November 1987 to December 1988; (2) the capitation payments come regularly at the beginning of each month with no delays for claim forms to be authorized.

However, 74 percent of physicians note that they spend more time on paperwork than under the old Medicaid program. This is mainly due to the referral authorization forms which the primary care provider (PCP) must complete in order for a patient to receive any care outside his or her office. Often patients go to specialist offices or to the emergency room without contacting the PCP. This creates great difficulty for the PCP who must then hunt down the details and authorize the visit retroactively or else the other provider is not compensated. This is an aspect of the practice style which brings frustration to many Health Plan of San Mateo case managers.

Thus, policy strategies employed in experimental case management programs will influence physician decision making by impacting three areas of physician concern: self interest, concern for patients and concern for the society as a whole. An understanding of the determinants of physician behavior assists in the predicting of effects of specific policy changes.

Before considering the survey data and looking at the issues raised above in more depth, a conceptual framework for the roles of the case manager will be explored. In this way, it will be demonstrated that all of the influences on physicians considered in this chapter will have varying effects depending upon the role that the physician is playing. Thus, the varied conflicts facing the physician in the role of case manager will be elucidated.
A Behavioral Model of the Case Manager

In Chapter III, the theoretical basis of managed care as a cost control strategy was presented. It was noted the role of the case manager is not defined explicitly in any managed care systems (Berenson 1985). Furthermore, many physicians have not been adequately trained to perform case management functions. In this section, the sometimes conflicting roles that the case manager must perform are examined. Additionally, the policy implications of these roles is discussed with respect to modifying physician behavior. Lastly, research into physician attitudes regarding case management is explored.

Hurley has developed a model for case management which identifies four distinct roles for the primary care physician: (1) healer; (2) clinical expert (3) coordinator of services; and (4) rater of services (1986). Discussion of these roles will help illustrate the conflicts which arise and will be useful in predicting the physician behavior in a particular case management system. For example, a capitated case management system will emphasize particular roles while a fee-for-service system will emphasize others.

The practice style that a physician develops will be the result of the influences discussed previously in this chapter. Within each practice style, a physician functions in many roles. A partial listing of those roles would include:

advocate
agent
broker
clinician
confidante
Hurley's model suggests that the roles can best be illustrated by constructing two intersecting axes. The horizontal axis, skills orientation, ranges from clinical to managerial. The vertical axis, service orientation, ranges from patient interested to self interested. Within these axes, we can fill in the roles.
The service orientation axis can also be understood as a risk axis. Greater orientation toward patient concerns would reduce the attention placed on physician concerns. Increasing the importance of treatment consequences from the perspective of the physician would mean less concern about the consequences from the perspective of the patient.

The skills orientation axis demonstrates the fact that a physician must integrate very different skills in making any treatment decision. The clinical skills relate to the physician's knowledge of appropriate tests and how to incorporate the results within the body of biomedical knowledge. The managerial skills relate to the ability to do cost-benefit analysis and predict the optimal allocation of resources for this case. The physician must also take into consideration standards of care in his medical community as well as standards required from a legal perspective. On a global level, a physician may consider the implications for society of particular treatment strategies.

Examining this model helps give insight into what sort of behavior can be expected from various case management systems. For example, increasing the physician's risk would expand the expert and rationer functions. Thus, we can expect that payment systems which place the physician at financial risk will result in less orientation toward the patient and more toward the physician. This is not necessarily an undesirable result -- it may be that this would result in fewer unnecessary services being provided.

Furthermore, it follows that it would be less likely to see the rationer function performed in payment systems which do not place the case manager at financial risk. This fact has been corroborated by the failure of the SAFECO and the Monterey Health Initiative which were discussed in Chapter II. Moreover, financial incentives have been added to cost-containment programs in
order to improve the efficacy of education and feedback (Egdahl & Taft 1986).

Administrative mechanisms could shift a physician along the skills orientation axis. Techniques such as utilization review, feedback in the form of statistical comparisons with colleagues and limitations in clinical therapies allowed, would all move a physician toward placing more emphasis on the managerial side of medicine, away from simply dealing with the results of clinical tests.

Hurley reaches the conclusion that a strong case management orientation is not possible without financial risk combined with some level of administrative mechanism. Simply placing the physician at risk would move him or her toward the expert and rationer orientation, however costs may actually rise because of increased focus on expert role. Simply using administrative mechanisms would not be effective because the physician's response to this may be to exploit the system to its fullest in order to obtain the greatest number of services for the patient by finding loopholes (a common response to DRG's)(Notman, et. al. 1987).

It is clear that these policy strategies pose new conflicts for physicians. Increasing the financial risk under which the physician practices while also increasing administrative control results in accentuating the imbalance between the patient and the physician as well as between clinical and managerial skills.

Complaints with capitated case management systems have been noted in the literature. Physician attitudes regarding changes in the health care system have not been studied in great detail and most of the studies are anecdotal (Hickson, Altemeier & Perrin 1987). The opinions discussed below will be examined more fully in Chapter V, the study of the Health Plan of San Mateo.
Several areas have emerged as problems related to patients. The most difficult problems involve discrepancies among insurer's promised benefits, patient expectations and physician perceptions of what is medically indicated. An example would be the case of a woman who presents at her doctor's office with a complaint of shakiness and anxiety following meals. The symptoms are inconsistent and are not associated with any particular foods. The woman remarks to the physician that she knows that allergy testing is a covered benefit and she wants to have the tests done. After consultation with the allergist on the group staff, the physician learns that allergy testing is not indicated in this case because of inaccuracies of the results. After relating this information to the patient, she asks him if he is not giving the tests because she is covered by a captitated insurance plan. Despite his assurances, the patient wonders whether her doctor is more concerned about her health or about cutting back on treatments (Ellsbury 1986).

Another difficult area with patients occurs when the role as healer conflicts with role as rationer (Ellsbury 1986). This could be a situation in which a physician suspects that a treatment may be marginally beneficial, but the resources could be used much more cost-effectively on another one of his capitated patients. He tries to keep costs within guidelines, but feels uncomfortable about withholding a potentially beneficial treatment. He also knows that giving the treatment would reduce a great deal of anxiety and stress in his patient.

Physicians also express dislike for the reduced access to health care encountered by their patients in a capitated system.

Lastly, physicians note frustration in case managing their patients when they continue to seek treatment from specialists directly. Often patients have longstanding relationships with a specialist and do not seek prior
authorization from their primary provider. The case manager must then authorize the visit retroactively, often without ever seeing the patient. Choosing to not authorize the visit would lead to the specialist not being paid and possibly a poor working relationship with consultants in the future.

Several physician-related issues present areas of difficulty. Controlling services performed by consultants can be difficult, particularly if the consultants do not keep the primary care provider abreast of the treatment progress.

Conflicts between short and long-term goals are often frustrating. For example, preventive services may cost the physician a great deal today and the effects may not be reaped until years later when it is likely that the patient will no longer be in his or her practice (Like 1988).

Physicians often express discomfort with the financial risk involved with capitation (Ellsbury, Montano & Manders 1987). Many primary care physicians do not believe that it is appropriate that they be made financially responsible for their patient’s health.

Lastly, many physicians perceive a loss of control when it appears that the care of their patients is being dictated by large insurance corporations (Ellsbury, Montano & Manders 1987).

Administrative issues can also present problems to the gatekeeper. The physician may not feel that he has been adequately educated about his role. Physicians also express concern that the plan does not fully educate beneficiaries how to properly use the system. The completion of referral authorization forms often results in increased time spent on administrative tasks. Physicians may sense frustration with the loss of continuity when patients gain and lose eligibility. This can make it very difficult to case manage. Another common concern is that the capitation rate is not adequate
for some more expensive patients (Like 1988).

Some physicians also express concern about larger health care system issues. For example, some fear that what is occurring is the development of a multietiered system in which only the poor may be faced with dealing with issues of rationing. There are also conflicts between financial and legal liability (Like 1988; Ellsbury 1986). Physician legal liability concerns pressure them to do more while financial considerations emphasize reducing services.

In summary, for many physicians, these issues result in frustration and increased stress in attempting to resolve the conflicts (Ellsbury, Montano & Manders 1987). This may be due in part to the fact that many physicians are not trained to adequately deal with all of these additional issues imposed upon them.

However, physicians have also identified advantages in a capitated managed care system. With respect to patient issues, some physicians report that they are able to achieve better coordination of care, including advice regarding referrals and specialty care. Some have noted decreased health costs for the patients and improved continuity of care (Ellsbury, Montano & Manders 1987).

Some physicians enjoy the role of the case manager and are gratified by the increased importance of the primary care role in health care. Furthermore, some physicians welcome the increased practice volume, despite the higher demands on their time for administrative work. Lastly, it is felt by many case managers that controlling patient use of specialty and hospital services is an appropriate role for primary care physicians to play (Davidson & Fox 1986).

From an administrative standpoint, many case managers prefer no longer
hassling with claim forms. A capitation payment is prompt and reliable. Physicians also demonstrate some concern for the society's use of health care resources and are encouraged by the reduction of unnecessary utilization of services that they hope case management will achieve (Ellsberry, Montano & Manders 1987).

As we have seen, the data suggest that physicians only consider the global policy issues of health care in a remote manner. As a whole, physicians have not made significant efforts to educate themselves regarding the rationale of the policies or the research behind the implementation of particular strategies (Notman, et. al. 1987). At the same time, the allocative role of physicians places them in the position of determining how as much as 90 percent of health care funds are used (Eisenberg 1985b). Thus, physicians are in the position of being able to either augment or impede change in cost-containment strategies.

For cost-containment to be successful, a strategy should include ongoing education, feedback, and face to face contact with respected clinicians in the community. The strategy must address the fact that clinical decision making is influenced by factors relating to physician self-interest, interest in the patient and concerns related to the society as a whole.

Increasing the risk that a physician faces combined with administrative controls in order to modify the physician's practice orientation has resulted in both positive and negative feelings from many physicians. Now, let us examine the results of the study of the Health Plan of San Mateo to determine whether the capitated managed care system has modified behavior and how physicians have responded to these changes.
CHAPTER V

THE PHYSICIAN SURVEY
Currently, there are very few data available about how changes in the financing of health care affect physician attitudes, priorities and behaviors (Hickson, Altameier & Perrin 1987; Ellsberry, Montano & Manders 1987). This survey was conducted in order to examine the consequences of capitated managed care from the perspective of the primary care provider. Physician attitudes and behaviors were assessed in five aspects of primary care: (1) access to health care, (2) preventive medicine, (3) practice style, (4) satisfaction and (5) areas of improvement. The results of the survey will be discussed with respect to policy implications.

BACKGROUND

The Health Plan of San Mateo (HPSM) is a Medicaid managed care demonstration project which commenced operations on December 1, 1987. In 1982, legislation was passed (AB 799) which created the California Medical Assistance Commission (CMAC) and authorized the commission to implement pilot projects that would explore new financing mechanisms for Medicaid. The goal is to eventually phase out fee-for-service payments and replace them with capitated systems.

The HPSM is a health insuring organization operating under a contract with the California Department of Health Services. Operated by the County of San Mateo, the HPSM assumes full responsibility for the provision of all Medicaid services in the County. Management of the health care system and contracting with the providers of the care is performed by the plan.

Case management is limited to primary care providers who have the
responsibility of providing and authorizing all care for their patients. Case managers are paid a capitated rate with shared savings opportunities. Specialists in the health plan are paid negotiated fee-for-service rates and hospitals receive a per diem negotiated rate.

Membership in the health plan is mandatory for all Medicaid beneficiaries who are residents of San Mateo County.

Further discussion of the organizational structure of the HPSM can be found in Chapter II of this paper.

San Mateo is a large and diverse County located in the San Francisco peninsula of northern California. As of December 1988, there were an estimated 28,700 individuals eligible for the HPSM. This populations includes large populations of east Asian, hispanic, and black ethnic groups.

METHODS

The survey was mailed 76 primary care providers of whom 65 returned the survey for an 86% response rate. Surveys were only sent to the case managers who had 50 or more HPSM patients in their practice. The population of case managers is composed of two subpopulations: (1) physicians who contracted directly with the health plan as a case manager and (2) physicians working in a clinic or medical group which contracted with the health plan. The total population of contracts to providers with more than 50 patients was 63. Of this number, 50 providers were individual physicians who contracted directly with the health plan, each of whom was sent a survey. The remaining 13 providers were clinics and medical groups. One survey was sent for every two physicians working in that clinic or group, resulting in a total of 26 surveys. Therefore, every
provider with 50 or more HPSM patients as of March 1989 was sampled.

The surveys were numbered so that nonresponders could be identified for followup. Confidentiality and anonymity were assured. The response rate for Group A, individual physicians who contracted with the health plan, was 90%. The response rate of Group B, physicians working in clinics or groups that contracted with the health plan, was 76%. The lower response rate of the clinic populations is probably due to the fact that these surveys were sent to the clinic directors who were instructed to distribute them to the staff physicians. This was done because the names of the staff physicians were not available. However, the response rate in both groups was high enough to insure validity of results.

The demographic characteristics of the population are summarized in Table 1. The age of responding physicians varied from age 30 to age 75 with a mean age of 50. The length of time in practice ranged from 1 to 43 years with a mean of 19 years. The sample was composed of 85% male and 15% female physicians. Ethnically, the physicians represented the following groups: white 58%, Asian 18%, black 11%, hispanic 10%, other 3% (3 physicians did not respond). The specialties of the primary care providers were in the following distribution: pediatricians 38%, internists 34%, family physicians 17% and general practitioners 11%. In summary, the demographic characteristics demonstrate a well distributed population representing the major subgroups of primary care physicians.

RESULTS

Only 2 physicians responded that they did not provide Medi-Cal services under the old Medi-Cal system. Their responses were included in the nonresponder
category for questions which required comparison between the traditional Medi-Cal program and the HPSM.

Descriptive Statistics

Access to Health Care

The Medicaid program was implemented with two principal goals: (1) to improve access to health care services for the nation's poor and (2) to provide those services within the mainstream of American medicine. As discussed in Chapter IV, declining physician participation in Medicaid has resulted in decreased access to care for beneficiaries and increased program costs (Davidson 1982; Perloff, Kletke & Neckerman 1987). In light of these developments, it is important that policy makers consider the impact of cost-containment strategies on the level of physician participation in the Medicaid program.

The mean number of patients per practice in Group A was 212 and the median was 146. The numbers ranged from a low of 54 patients to a maximum of 146. In Group B, the mean number of patients per site was 515 and the median was 359. The numbers ranged from a low of 118 patients to a high of 1907. The numbers were obtained from HPSM records in March 1989.

The physicians in the sample reported that the percentage of their practices devoted to HPSM patients ranged from 1-5% to over 50% (see figure 1). The mode was 6-10%. When asked to compare the number of Medi-Cal patients seen in their practice before and after HPSM, 49% reported that the numbers had increased under HPSM, 12% said the number had decreased and 39% had no change as shown in figure 2 (6 physicians did not respond). Of physicians who had increased their participation in Medi-Cal, the mode amount
of increase was 10-25% (see figure 3). When asked whether the waiting period for getting a Medi-Cal appointment in their office had increased or decreased, 10% said that the wait was longer while 87% said that there had been no change and 3% reported that the wait was shorter.

Therefore, nearly 50% of physicians participating in the HPSM increased the number of Medi-Cal patients seen in their office under the new health plan. While this has resulted in an increased waiting time to schedule an appointment in 10% of the offices, 90% reported no change or a decrease in waiting time.

Preventive Medicine

Under a prospective payment, case managed system, the incentive exists for provider to provide preventive medical services and to follow up any treatments prescribed to ensure their efficacy. Two parameters of preventive medical services were inquired about in the survey: (1) the use of health educational materials and (2) the number of follow up visits scheduled with their HPSM patients.

The physicians were asked whether they hand out health educational material to more, fewer or the same number of patients as before the HPSM. 94% of physicians noted that their use of educational materials was the same as prior to HPSM. 3% stated that handed out more materials and 3% said they handed out fewer (3 physicians did not respond).

The survey also inquired about whether physicians schedule more, fewer or the same amount of followup visits after seeing a patient as compared to before HPSM. The aggregate data revealed that 78% of physicians in the sample responded that they schedule the same number of followup visits while 18% said
they schedule fewer and 5% said that they schedule more. It was interesting to note that 7% of physicians in Group A reported that they schedule more followup visits while no physicians in Group B noted scheduling more visits.

On these parameters, it does not appear that HPSM physicians have increased their use of preventive medical services. There may be a slight increase in the use of follow up visits in physicians who are directly financially at risk. In a case managed Medicaid program, there are several possible explanations for the lack of an increased use of preventive medical services. First, implementing these strategies may be costly, and the benefits may not be reaped for many years when it is doubtful that the patient will still be in the same practice. Secondly, without clearly defined goals for the case management function, many physicians may feel as though the only thing that has changed is that they are required to be "gatekeepers". In summary, it is not clear that one can assume that case managed care will improve the use of preventive medical services.

Practice Style

One goal of case managed capitated health care systems is to change the practice style of physicians in order to reduce unnecessary utilization of medical services. As discussed in Chapter IV, a health plan which provides financial incentives along with regulatory guidelines would be expected to create more rationing behavior. Furthermore, it was shown that if physicians were primarily affected by the regulatory features, utilization could rise through finding loopholes in the requirements. This behavior would allow the physician to maximize his own or his patient's benefit at the cost of the health plan. To address these issues, aspects of practice style were included in the survey. This issue is particularly relevant to the HPSM because after
one year of operation, the target budget for specialty services had been exceeded by greater than 50%.

When asked if they understood their responsibilities as case manager, 88% percent of physicians responded "yes", while 5% responded "no" and 7% did not respond.

Physicians were asked whether they spend more, less or the same amount of time with their patients at each visit as compared to under the old Medi-Cal system. 74% of physicians noted that they spend the same amount of time during each visit with the patient, while 19% said that they spend more time and 7% stated that they spend less time than before HPSM started (3 physicians did not respond). An important difference was noted between the two subpopulations. Twenty-four percent of Group A physicians stated that they spend more time with the patient, but only 10% of Group B physicians responded similarly (see figure 4).

Physicians were also asked about the amount of time they spend on paperwork. Seventy-seven percent of physicians said they spend more time on paperwork under the HPSM than they did under the old Medi-Cal program. Fifteen percent said they spend the same amount of time, while 8% said that they spend the less time (3 physicians did not respond).

For the following questions, physicians were asked to respond to a series of statements about their opinions regarding capitated managed care and how it has affected their treatment plans. Their responses were given on a 5 point Likert scale as follows: strongly disagree, somewhat disagree, no opinion or no change, somewhat agree, strongly agree.

Physicians were asked whether they felt that they make decisions regarding referrals for their Medi-Cal patients differently since HPSM began. Seventy-two percent of physicians responded that they do not make decisions
differently, while 28% agreed with the statement (8 did not respond). When asked to explain how they make decisions differently, the most commonly given responses were that it is harder to find specialists willing to accept HPSM patients. The next most common response was that they are more selective in which patients are referred. It was also mentioned that their patients are more demanding of referrals and that there is more time and paperwork involved in authorizing referral visits and hospitalizations.

When asked if they felt that they are having a stronger influence on their patients’ use of referrals specialists since the HPSM began, the aggregate data revealed that most physicians agreed with the statement (see figure 5). If the the responses strongly agree and somewhat agree are summed and then the same is done for the disagree responses, some important differences emerge between the two subpopulations. It is shown in figure 6 that 71% of physicians in Group B agreed with this statement while only 50% of those in Group A agreed (4 did not respond).

Physicians were asked if they felt that they were more likely to refer time-consuming patients to specialists. While 47% of physicians in Group B disagreed with the statement, only 36% of those in Group A did. It was even more notable that 39% of physicians in Group A agreed that they are more likely to refer time-consuming patients while only 21% of Group B physicians agreed as shown in figure 7 (4 did not respond).

When asked if they agreed with the statement, "I think that I can give my patients better health care under the HPSM case management system than under the traditional Medi-Cal system", 42% of physicians disagreed, with 32% disagreeing strongly (see figures 8 and 9). Thirty-four percent felt that there was no difference and 24% agreed with the statement (3 physicians did not respond).
The data regarding practice style fail to demonstrate any clear rationing behavior. Most physicians do not spend more time with their patients, nor do most make decisions regarding referral visits differently. In fact, there may be an unintended effect in that 41% of Group A physicians noted that they are more likely to refer time-consuming patients to specialists rather than dealing with them on their own. Of physicians that remarked that they make decisions regarding referrals differently, the most common reason was that it was harder to find specialists willing to accept HPSM patients. Thus, some cost containment may be occurring simply due to the gatekeeper effect.

Further, 50% of Group A and 71% of physicians in Group B noted that they feel that they are having a stronger influence over their patients’ use of specialist referrals under the case managed system.

The differences noted in Group A and B may help to explain the apparent lack of rationing behavior. Group B physicians were more likely to report that they are having a stronger influence over their patient’s use of referral services and that they are less likely to refer time-consuming patients. Because Group A physicians are more directly at financial risk, they may refer patients more readily. Apparently, the incentive to reduce utilization of specialty services in their region (as discussed in Chapter III) may be too small and too indirect to induce rationing behavior. It has been noted that in financial arrangements in which the physician is responsible not only for his own behavior, but for the collective behavior of a large group of physicians, there is little incentive to change behavior (Caldwell 1988).

This appears to be the case in San Mateo where the return of the withheld capitation funds, as well as any bonus, is determined by the behavior of the region. This has the implication that it may be necessary to increase the
direct financial risk on the individual provider or to outline more clear guidelines and/or education with penalties regarding the role of the case manager.

Satisfaction

Physician satisfaction with a health plan will remain an important issue for as long as physician participation in the health plan is not legislated to be mandatory. Furthermore, physician satisfaction in the health plan will help predict whether physicians will follow the intent of guidelines or whether they attempt to circumvent the regulations by finding loopholes in the system. Several questions were included in the survey in order to assess physician satisfaction with capitated medical care generally and the HPSM in specific.

Physicians were asked whether they agreed with the idea that withholding a portion of the capitation payment was an appropriate incentive for them to serve as a case manager. In the aggregate data, 61% disagreed with this statement while 19% agreed and 20% had no opinion (11 did not respond). An interesting contrast was noted between the subpopulations. Only 11% of Group A physicians agreed with this statement while 33% of Group B physicians agreed. Thus, physicians that directly feel the effect of the withheld portion were three times less likely to feel that it was an appropriate incentive. It is also worth noting that over 60% of the sample disagreed with the idea (see figure 10).

When asked if they felt that it was appropriate for primary care providers to share in the financial responsibility for the management of health care, equal percentages agreed as disagreed (46% and 44% respectively; see figure 12). Ten percent had no opinion with 4 physicians not responding.
Once again, an interesting difference was noted in the subpopulations. While 50% of Group A disagreed, only 33% of Group B disagreed. Group A was much more polarized as only 3% had no opinion as opposed to 24% of Group B having no opinion (see figure 11). Overall, physicians appear to be split down the middle on this issue.

When asked if they agreed with the statement that the HPSM system is better to work with than the old Medi-Cal system, 58% disagreed and 29% agreed while 14% felt that it was the same (see figure 13). Interestingly, 65% of Group B physicians disagreed while only 54% of Group A disagreed. In figure 14, note also that 44% of Group A disagreed strongly while 25% of Group B disagreed strongly. More physicians in Group A felt that it was no different (18% vs. 5%).

It is worth noting that 46% of the physicians felt that it is appropriate for primary care providers to share in the financial responsibility for the management of health care. However, it appears that this population does not feel that the withholding of a portion of their capitation payment is an appropriate incentive for performing the case manager function. Moreover, only 23% felt that the HPSM has been better to work with than the old Medi-Cal system. This suggests that physicians may be less against the idea of sharing financial risk than they are in disagreement with the way in which the HPSM accomplishes that objective.

The 25% of individually contracting physicians who like the HPSM system better may feel so because the payment mechanism is more reliable and less difficult. For these individuals, the problems associated with increased paperwork may be offset by increased reliability in payment. Physicians who are working in a clinic or group which has contracted with the health plan do
not see the benefits of prompt payment directly, thus the problems associated with paperwork may be most important. As will be shown in the correlation data, physicians who responded that they spent more time on paperwork were less likely to feel that the HPSM was better to work with than the old Medi-Cal system ($r = -0.2655, p < 0.05$).

Areas of Improvement

An open-ended question was included on the survey for physicians to note what one aspect of the program they would improve. Overwhelmingly, the most frequently noted response was for the health plan to streamline the paperwork required of the case managers, of which the referral authorization form was the most onerous. This has become a problem since many patients do not seek care at the primary care physician's office before going to see a specialist. The primary care physician must then spend a good deal of time trying to find out why the visit was made and determine whether or not he should authorize the services retroactively. If he decides not to authorize the visit, the specialist will not be paid, thus creating tension between the consultant and the primary care provider. This is the most troublesome area for case managers within the HPSM.

Next in frequency was the issue of patient behavior and education. Many providers feel that the HPSM patients do not understand how to appropriately use the system. This leads to patients seeking care at specialists offices and emergency rooms, without first seeing their case manager. Moreover, several providers noted that the patients were often demanding of specialist referrals if they were denied and then became ungrateful of the services that were provided. This illustrates the issue described in Chapter IV where the
conflicting demands of the rationer role and the patient advocate role can put strain in the physician-patient relationship.

The next most mentioned area was the problem of "on-off" eligibility. AFDC families are required to submit income forms on a monthly basis in order to maintain their Medi-Cal eligibility. If a form comes in late during one month or if their income is above the limit, they are removed from the eligibility list and their case manager does not receive a capitation fee for that patient. When the patient shows up at the physician's office, the name is no longer on the list and the physician may turn the patient away. Often the physician will see the patient anyway because there is no place that the person can go since he will not be on anyone's capitation list. Usually, the problem is that the form was submitted late and not that the person is ineligible. Months later, the patient will be determined to be retroactively eligible and the physician will receive a fee-for-service payment for any services provided. This all becomes very complicated and often the time involved is not worth the amount of money to be reimbursed.

On-off eligibility can also be a problem if a patient truly is ineligible for a month and then becomes eligible again later. The patient may or may not sign up with the same case manager that he had before. If the patient is assigned to a new case manager, any efforts that were made in the area of continuity of care and preventive health services will not be reaped by the original provider. It was also recommended that the health plan reassign patients to their previous PCP if the person does not pick a provider. This was recently made a policy of the health plan.

The next most common recommendation for improvement was to increase the amount of the capitation payment. Physicians did not feel that the amount was adequate. Capitation rates for AFDC patients vary according to region of the
county from $4.94 per month to $5.65 per month. (Memo to Health Commission, 4/5/89).

Other problems noted were difficulty in finding specialists who accept HPSM patients, requests to return to fee-for-service, problems with the health plan administration and putting a stop to "Medi-caid mills."

Correlations

Some important correlations were found between the responses to the individual questions. The Pearson correlation coefficients are summarized below.

Access to Health Care

It was found that the larger the percentage of HPSM patients in a physician’s practice, the more likely it was that:

(1) the waiting period for an appointment had increased \( (r = .3293, p = .004) \). This correlation was even stronger in Group A, physicians contracting individually \( (r = .5175, p < .001) \).

(2) the physician felt he had less control over his patients use of specialists services \( (r = -.3058, p < .05) \). This correlation was strongest in Group B, physicians working for a provider who had contracted with the health plan \( (r = -.5493, p = .005) \) and lower in Group A, physicians individually contracting \( (r = .2331, p = .077) \).

(3) the physician felt less able to give their patients better health care under the HPSM than under the traditional Medi-Cal system \( (r = -.2038, p < .100) \).

It was also found that the more a physician had increased his Medi-Cal patients in his practice, the more likely it was that:

(1) the physician did not feel that the capitation withhold was an appropriate incentive for performing the case manager role \( (r = -.2468, p < .1) \).
(2) a physician in Group A made decisions regarding specialty referrals differently ($r = .2805, p < .1$).

(3) a physician in Group B felt that the HPSM was better to work with than the traditional Medi-Cal patients ($r = .7197, p = .009$).

(4) the physician had attended an informational meeting about the health plan at which the importance of having more patients under capitated payment was expressed. This effect was important in Group A physicians who have direct control over the number of patients in their practice ($r = .3540, p < .05$).

Physicians who noted that the waiting time to schedule an appointment in their office had increased were more likely to:

(1) have a higher percentage of their practice as Medi-Cal patients ($r = .3242, p = .005$). The correlation was even stronger in Group A ($r = .5059, p < .001$).

(2) respond that they spend more time with the patient than before HPSM ($r = .2580, p < .05$).

(3) respond that they spend more time on paperwork than before HPSM ($r = .1662, p < .1$).

Preventive Medicine

Physicians who responded that schedule more followup visits were more likely to:

(1) have been in the health plan for a shorter period of time ($r = -.2429, p < .1$) for physicians in Group A.

(2) spend more time with the patient ($r = .3901, p = .001$). This correlation was much stronger in Group B ($r = .6236, p = .001$) than in Group A ($r = .3249, p = .019$).

(3) spend more time on paperwork ($r = .4108, p < .05$) in Group B.

(4) to not refer more time consuming patients ($r = -.2066, p < .1$).

(5) to feel that they can give better health care under the HPSM system ($r = .2660, p = .018$).

(6) to feel that the new health plan is better to work with ($r = .3010, p = .010$).
Practice Style

Physicians that noted that they spend more time with the patient under the HPSM plan were more likely to:

(1) schedule more followup visits ($r = .3901, p = .001$). This correlation was very strong in Group B ($r = .6230, p = .001$).

(2) spend more time on paperwork ($r = .2956, p = .010$).

(3) feel that withholding a portion of the capitation payment is an appropriate incentive for them to function as case manager ($r = .2292, p < .1$).

(4) feel that they make decisions regarding referrals differently under the HPSM ($r = .2819, p = .050$) in Group A, while the correlation in Group B was nonsignificant.

(5) feel that it was appropriate for PCP’s to share in the financial responsibility for the management of health care ($r = .1813, p < .1$).

Physicians that noted that they spent more time on paperwork were more likely to:

(1) spend more time with the patient ($r = .2956, p = .010$). This effect was stronger in Group A ($r = .3406, p = .016$) than in Group B where the correlation was not significant.

(2) not feel that it is appropriate for a portion of the capitation payment to be withheld as an incentive to work as case manager ($r = -.4355, p = .001$). This negative correlation was very strong in Group A ($r = -.6211, p < .001$).

(3) feel that it is appropriate for the primary care physicians to share in the responsibility for the management of health care ($r = .2141, p = .053$).

(4) not feel that the HPSM has been better to work with than the old Medi-Cal system ($r = -.2408, p < .1$) in Group A.

Individuals responding that they make decisions regarding referrals
differently since HPSM began were more likely to:

(1) have a greater number of HPSM patients \( (r = .5235, p = .001) \).

(2) have made a greater increase in the number of Medi-Cal patients in their practice \( (r = .2805, p < .1) \).

(3) spend more time with the patient \( (r = .1902, p < .1) \), particularly in Group A \( (r = .2819, p = .050) \).

(4) feel that it was appropriate for PCP’s to share in the financial responsibility for the management of health care \( (r = .1874, p < .1) \).

Those that responded that they had a stronger influence over their patients' use of specialist services under HPSM were correlated with:

(1) having a smaller percentage of their practice as HPSM patients \( (r = -.2691, p = .019) \). This correlation was very strong among the Group B physicians \( (r = -.5493, p = .005) \) and not significant in Group A.

(2) having increased the percentage of their practice that is HPSM patients by a smaller percentage \( (r = -.2506, p < .1) \).

(3) believing that the capitation withhold is an appropriate incentive for performing the case management function \( (r = .4390, p = .001) \) and \( (r = .5676, p < .001) \) in Group A, while the relationship in Group B was nonsignificant.

(4) believing it is appropriate for the PCP to share in the financial responsibility for the management of health care \( (r = .5672, p < .001) \) in Group A. However, Group B physicians had a negative correlation \( (r = -.4591, p = .018) \).

(5) believing that they can give their patients better health care under the HPSM system \( (r = .6099, p < .001) \). This correlation was very strong in Group A \( (r = .7283, p < .001) \).

(6) believing that the HPSM system is better to work with than the old system \( (r = .5213, p < .001) \) in Group A.

Physicians that responded that they were more likely to refer time consuming cases to specialists also responded that:

(1) they schedule fewer followup visits for their patients \( (r = -.2066, p < .1) \).
Physicians that reported that they are able to give their patients better health care under the HPSM system also responded that:

(1) HPSM patients were a lower percentage of their practice ($r = -1814$, $p < .1$).

(2) they schedule more followup visits than before HPSM ($r = .2660$, $p < .05$)

(3) they believe that the capitation withhold is an appropriate incentive for performing the case management function ($r = .5267$, $p < .001$)

(4) they believe that they have a stronger influence over their patient's use of referral services ($r = .6099$, $p < .001$). This correlation was very strong in Group A ($r = .7283$, $p < .001$).

(5) they believe that it is appropriate for PCP's to be financially responsible for the management of health care ($r = .3160$, $p = .007$). This correlation was especially strong in Group A ($r = .5094$, $p = .001$).

(6) they believe that the HPSM system is better to work with than the old Medi-Cal system ($r = .8638$, $p < .001$) in Group A and ($r = .6418$, $p = .001$) in Group B.

CONCLUSIONS

Overall, it has been shown that most physicians (1) have not changed their behavior, (2) do not feel that they can provide better health care to their patients and (3) do not believe that the HPSM is better to work with than the old Medi-Cal system. However, there are some important correlations which may suggest reasons for this.

Paperwork was most commonly identified as the one aspect of the problem that providers would change. It was also shown that physicians who were performing more paperwork were less likely to like the HPSM program better. This may corroborate anecdotal comments made to this researcher by physicians who stated that they are not in this program to make an extra $5 per month. Many perform these services out of a sense of obligation to society and they would like to do that service with the least amount of paperwork and time
demands as possible.

Moreover, it was shown that the physicians that had higher amounts of HPSM patients in the practice were more likely to be dissatisfied with the program. This may also be a reflection of the administrative demands.

It is important not to overlook the fact that nearly half of physicians do feel that it is appropriate for primary care providers to share in the financial responsibility for the management of health care. But most do not feel that the withholding of a portion of the capitation payment is an appropriate incentive for performing the case manager function. It appears that physicians are not as much against sharing the financial responsibility as they are against the way in which the HPSM accomplishes that goal. It is doubtful that the amount of money withheld is a real incentive to change behavior as it was shown that there was little change in the use of educational materials, follow up visits, or the way in which decisions are made about the use of referral services.

With respect to access to health care, physicians have increased their level of participation in the Medicaid program, however this has resulted in less control over their patients' use of specialty services and a sense of not being able to give as good of health care to their Medi-Cal patients.

Physician practice styles have not been changed much on the whole, but it is worthwhile to note that physicians noting that they spend more time with their patients were more likely to make decisions regarding specialty referrals differently and felt that it was appropriate for them to share in the financial responsibility for care. Moreover, physicians feeling that they have more control over their patients' use of specialty services also strongly feel that they can provide better health care, that the HPSM system is better to work with and believe that their sharing in the financial responsibility is
appropriate.

Lessons learned in a Medicaid managed care program in Massachusetts can corroborate some of these findings (Prattas & Handler, 1987). It was found that physicians generally proceeded to practice in their customary manner. Without individualized information regarding referral patterns and feedback on performance, there was little incentive for physicians to behave as a rationers. Some physicians did improve their referral tracking systems, but did so more for their own purposes rather than in an effort to achieve savings at the end of the year.

These data can direct policy options in several directions. It has been noted that costs for specialty services in the health plan are over budget. One possibility is that there was a large amount of latent disease in the community which was discovered by the implementation of the case managed system with the linking of every patient with a physician. While this may be true, the possibility also exists that this is due to increased physician referrals. There does not seem to be very much evidence that primary care providers are behaving as rationers of health care. In order to encourage a change in behavior the health plan could (1) increase the financial risk facing physicians or (2) provide clear guidelines for the behavior of a case manager and identify and educate physicians who appear to consistently refer large numbers of patients inappropriately. It is likely that increasing the financial risk facing physicians would result in physicians leaving the program. Drastically increasing the benefits that a physician could earn for cost effective behavior is another option, however it is not clear from where these funds would come. Strong utilization review with clearly explained guidelines appears to be a reasonable first step.

However, before any of the above changes are made, it is clear that a
reduction in the paperwork must be achieved in some manner. One option would be for the plan to instruct specialists not to see patients who do not already have prior authorization from their case manager. If this policy were coupled with more patient education, case managers might spend less time chasing down details of treatment in order to retroactively authorize care. Providing guaranteed eligibility for 6 months for Medi-Cal beneficiaries would reduce the problems associated with patients going on and off the capitation list from month to month. This is currently very time consuming as calls are made to see if the patient is really eligible and then forms are completed in order to receive payment for care that is provided. The HPSM administration has been trying to implement a guaranteed eligibility program, but has met significant resistance from the State Department of Health.

While the above policy options would not make capitated managed care a perfect system, they have the potential of improving the coordination of health care that is delivered and improving provider satisfaction with the system. Having explored the policy issues surrounding capitated managed care, I will not turn attention toward the ethical issues involved in prospective payment. The goal will be to demonstrate how the policy options and the ethical concerns can be integrated into a single system.
### TABLE I. DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

<table>
<thead>
<tr>
<th></th>
<th>All providers</th>
<th>Group A</th>
<th>Group B</th>
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<tbody>
<tr>
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<tr>
<td>Median age (years)</td>
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<td>56</td>
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<tr>
<td>Median length of time in practice (years)</td>
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<td>22</td>
<td>10</td>
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<td>Ethnic Group (as a % of the group)</td>
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<td><strong>100%</strong></td>
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<td>Specialty (as a % of the group)</td>
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<td><strong>100%</strong></td>
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<tr>
<td>Sex (as a % of the group)</td>
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<td><strong>100%</strong></td>
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Figure 1. Distribution of Responses by Proportion of HPSM Patients in Practice

Proportion of Practice Composed of HPSM Patients

- All Providers (n=64)
- Group A - Individual Contractors (n=43)
- Group B - Clinic/Group Contractors (n=21)
Figure 2. Distribution of Physicians Seeing Fewer, More, or the Same Number of Medi-Cal Patients Compared to Before HPSM Began
Figure 3. Percent Change in Number of Medi-Cal Patients Seen Since HPSM Began

Percent Increase or Decrease in Medi-Cal Patients Seen

- **All Providers (n=37)**
- **Group A - Individual Contractors (n=26)**
- **Group B - Clinic/Group Contractors (n=11)**
Figure 4. Physicians Spending More Time With the Patient on Each Visit

- All Providers (n=62): 19%
- Group A - Individual Contractors (n=41): 24%
- Group B - Clinic/Group Contractors (n=21): 10%
Figure 5. Question: I believe that I am having a stronger influence on my patients' use of referral specialists since HPSM began.
Figure 6. Question: I believe that I am having a stronger influence on my patients' use of referral specialists since HPSM began.
Figure 7. Question: Under capitation, I am more likely to refer time consuming patients to specialists.

- **All Providers (n=61)**
- **Group A - Individual Contractors (n=42)**
- **Group B - Clinic/Group Contractors (n=19)**

<table>
<thead>
<tr>
<th>Response</th>
<th>All Providers</th>
<th>Group A</th>
<th>Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>34%</td>
<td>41%</td>
<td>32%</td>
</tr>
<tr>
<td>No Change</td>
<td>21%</td>
<td>24%</td>
<td>38%</td>
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<tr>
<td>Disagree</td>
<td>47%</td>
<td>36%</td>
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</table>
Figure 8. Question: I think that I can give my patients better health care under the HPSM case management system than under the traditional Medi-Cal system.
Figure 9. Question: I think that I can give my patients better health care under the HPSM case management system than under the traditional Medi-Cal system.
Figure 10. Question: The capitation withhold is an appropriate incentive for me to serve in my role as case manager.
Figure 11. Question: In general, I feel that it is appropriate for primary care providers to share in the financial responsibility for the management of medical care.
Figure 12. Question: In general, I feel that it is appropriate for primary care providers to share in the financial responsibility for the management of medical care.

- **All Providers (n=61)**
  - Agree: 46%, 48%
  - No Change: 43%
  - Disagree: 50%

- **Group A - Individual Contractors (n=40)**
  - Agree: 10%, 24%
  - No Change: 3%

- **Group B - Clinic/Group Contractors (n=21)**
  - Disagree: 33%
Figure 13. Question: The HPSM has been better to work with as compared to the old Medi-Cal fee-for-service system.
Figure 14. Question: The HPSM has been better to work with as compared to the old Medi-Cal fee-for-service system.
CHAPTER VI

THE ETHICAL CHALLENGES OF PROSPECTIVE PAYMENT
As our society struggles to address the financial constraints imposed by rapidly rising health care expenditures, cost containment strategies are presenting critical issues of distributive justice which heretofore were not considered. Prospective payment of health care services has emerged as the most controversial of cost containment strategies. In this chapter, the issues surrounding the debate will be explored with an emphasis on policy options for the future.

Thus far, we have focused upon the economic, political and medical issues with respect to the efficacy of capitated prospective payment in achieving the goal of reduced health care expenditures. In this chapter, we will move away from practical concerns and ask whether or not our society should implement this strategy from a moral viewpoint, assuming that it would be successful.

The goal of prospective payment is to reduce medical care utilization by placing the providers of care under financial risk. Many critics of prospective payment argue that prospective payment would be acceptable if the reduction in expenditures came only from reducing unnecessary services. However, the problem is that prospective payment creates an incentive for physicians to reduce necessary health care as well. Furthermore, it is argued, it is unethical for the physician to be in the position of profiting by limiting the care that he gives. This point is magnified when we are considering a patient population that is typically less educated and may be less likely to challenge the authority of a physician.

In order to explore this argument from an ethical point of view, we should first carefully define its parameters. After analyzing the arguments on both sides of the issue, the particular case of the Health Plan of San Mateo's
capitated case managed system will be discussed.

Interstitial Justice

Our inquiry begins with the assumption that our society has decided that expenditures on health care must be reduced so that other social goals will not be neglected. Given this assumption, we must ask whether or not capitated prospective payment is the approach that we should take to achieve this goal. If, as a society, we choose to do nothing and remain with our current system, it is likely that we will see more rationing of health care to the poor in the form of inordinate emergency room waiting periods, inadequate primary health care due to insufficient numbers of providers willing to see these patients, and poor quality services in overworked municipal institutions. Clearly, if there are strategies available which would produce better quality health care than is present today, for fewer dollars, this would be preferred from an ethical standpoint. Capitated prospective payment and regulated fee-for-service appear to be the dominating financing mechanisms today. Thus, our task is one of evaluating competing policy options.

First, we must recognize that the question of capitated prospective payment (CPP) is not simply a question of whether or not CPP is ethical, but whether or not it is more consistent with our ethical principles than the fee-for-service mechanism (FFS). Second, we must understand that this is an ethical question which addresses one very specific mechanism of financing a public policy that we have agreed upon. This is not a universal question about the framework of our society. It is a question of interstitial justice (Fleck 1987), a question which addresses the social policies in the intersticies of our society and not its basic structure.

As a question of interstitial justice, we must recognize that we are not
dealing in the realm of the ideal, but must consider imperfect alternatives for an already imperfect world. Our task will be to determine which alternatives fit best with our ethical values. As Rawls writes:

In practice we must usually choose between several unjust, or second best arrangements; and then we look to nonideal theory to find the least unjust scheme. Sometimes this scheme will include measures and policies that a perfectly just system would reject (Rawls 1971).

Given the social concern for rapidly increasing expenditures on Medicaid, our question is now, how do we control the rate of rise of expenditures without imposing unacceptable losses in the quality of care delivered? Note that this question does not ask whether the entire Medicaid system is a just one or whether society has set proper priorities in deciding to reduce health care costs in the United States. Our question is a very limited one.

Leonard Fleck used the term "meliorism" in discussing this issue (Fleck 1987). Meliorism asks us to look at the claim

that we have done something morally commendable if, in any given problem/decision sphere, we can bring about a more just state of affairs, all things considered, even though this state of affairs may still fall far short of what might be required by ideal justice theory (Fleck 1987).

Thus, we can identify states of affairs which are "more just" or "less just" than others. A particular state may be the most feasible alternative and the closest that we can approach to our ideal given current realities.

A potential problem with this approach is moral complacency. This risk is lessened if society engages in open critical moral inquiry and this is linked to mechanisms of social change (Fleck 1987). The second problem is that we may leave in place deeper injustices (Daniels 1985). Fleck argues that this criticism is tantamount to saying that no change is good unless it completely overhauls the entire system. While this may be a noble ideal,
large scale change is often not possible. Moreover, incremental attempts at reform are usually the mechanism of change in large democratic societies. Meliorism will open up the forum for debate on the larger questions while small improvements are being made.

At this point, we must develop criteria for evaluating competing alternatives. Our society generally accepts the idea that fair processes and procedures have the following characteristics (Fleck 1987):

i. impartiality
ii. publicly open and observable
iii. respect all participants as free and equal persons
iv. yield fair terms of cooperation
v. are stable over a relevant period of time and yield results that are stable
vi. employ best methods of inquiry and best knowledge that is available
vii. provide a reasonable balance among competing considered judgments of justice relevant to a given decision sphere

The following is an evaluation of prospective payment on these criteria.

Justice and Capitated Prospective Payment

Capitated prospective payment (CPP) becomes an issue of distributive justice because of the scarcity of a desired resource. If we were only looking at services that had no social value or were in limitless supply, then there would not be an issue of distributive justice. Distributive justice evaluates the procedures and processes that a society implements in order to distribute scarce resources. We must keep in mind that in times of scarcity, everyone cannot have as much of this scarce resource as they would prefer. Some individuals may experience a loss in medical quality (hopefully only a marginal loss).

Arguments against CPP usually address the concern that this payment
mechanism presents an unethical incentive for physician to deny potentially beneficial care. This conflicts with physician's fundamental obligation to keep the needs of the patient foremost. Pellegrino describes the role of the physician as follows:

The prime focus of the physician's intention is the good of that individual patient, not some distant patient, not the good of society, or the greatest good of the greatest number. The physicians and, by extension, the health care institution, become agents of the patient's well-being at the moment of engagement. ...the patient's expectation that the physician and the hospital will act in his behalf is crucial. This is in fact the moral center of medicine, the moment of clinical truth.... The patient does not expect the physician to be an instrument of social and economic policy -- whether that policy is dictated by the physician's or society's value (Pellegrino 1978).

We will now focus on the issue directly at hand. It is apparent that the incentive to undertreat is present in a capitated payment system. However, it is also apparent that the incentive to overtreat is present in the fee-for-service system. One cannot argue that CCP is immoral simply because there is an incentive to bring into the doctor patient relationship financial issues outside of medical need because this is also present in the FFS system.

We may, however, wish to ask whether the CPP system is more unjust because the incentive to undertreat is so much more irresistible than are the incentives to overtreat in FFS. We may also wish to ask whether or not the consequences of the incentives in CPP are more undesirable than they are in the FFS arrangement.

Is the incentive more irresistible in CPP?

The nature of the conflict derives from the fact that the physician is both the provider and the creator of demand for his services. This fact is true regardless of the payment system. We must recognize that the conflict is
inherent in the profession -- not in the mechanism of payment. To say that we are concerned about these incentives means that we feel that the physician may be likely to disregard his moral obligation to be an advocate for the patients.

There are two ways in which a physician might overtreat: (1) by providing treatments of no medical benefit -- a violation of the physician's obligation to the patient, or (2) by providing treatments of marginal benefit, those with a high cost to benefit ratio relative to other uses of that resource. Let us explore the incentives which a physician faces under a fee-for-service system.

Until fairly recently, there was much less reason for concern about physicians overtreating because there was a shortage of physicians (Relman 1985). There were always ample patients, so it was not likely that a physician would violate moral obligations to patients and perform unnecessary treatments in order to maintain a desired level of income. However, as the number of physicians have risen in the past 25 years, the growth in competition for patients has engendered concerns of overtreatment. Furthermore, the amount of medical technology available to physicians has grown at a rate which has not been matched by research in the cost-effectiveness in that treatment. Thus, it has become easy for a physician to perform more treatments, keeping the patient interest in mind, without really knowing how much benefit is being derived, per dollar spent.

For example, Wennberg and Chassin have researched treatment of coronary artery bypass surgery and has found that treatment strategies (and cost) vary by region with little variation in medical outcome (Wennberg 1984; Chassin, et. al. 1986). It is also possible that a physician may neglect his moral obligations and perform treatments which clearly are not in the best medical interest of the patient.
The incentives present under a capitated system are diametrically opposed to those under the FFS system. Under CPP, a physician may be less likely to undertake a treatment which has low marginal benefit and high costs. A physician may also restrict clearly beneficial treatments in disregard of moral obligation to the patient. At present, there is no evidence to demonstrate that one may be more likely to undertreat under CPP than one is likely to overtreat under FFS (Begley 1987). However, for primary care physicians, the financial gains of providing unnecessary treatment are small. Under CPP, a less healthy patient may be quite costly for a primary care physician -- there is a strong incentive to undertreat and subtly suggest to the patient that better care may be available elsewhere.

Are the consequences of undertreatment worse than those of overtreatment?

In looking at this question, we must consider situations in which a particular treatment is clearly indicated separately from those situations in which a treatment plan is unclear. Relman argues that "when medical needs are not clear, patients should receive the benefit of the doubt" (Relman 1985). However, this question must be answered in the context of what will be done with the funds that are saved by restriction of treatment. The funds may be better allocated in the health care system to procedures of much clearer medical value -- such as preventive medical treatments that have been proven to be more cost-effective. Alternatively,

- the funds may be spent on social goods other than medicine
- the funds may be saved without any specified use
- the funds may go to physicians
- the funds may go to investors in health care corporations (Agich 1987)
These are just a few of the possible consequences of undertreatment. It is clear that without specifying the use of the funds, it is very difficult to say that the consequences of undertreatment are more unjust than the consequences of overtreatment.

In situations in which a particular treatment is medically indicated and it is not performed, the answer is more straightforward. Undertreatment in cases where the medical value of treatment are clear would be a violation of a physician's moral obligation to the patient. Moreover, overtreatment in cases where the treatment is clearly not indicated would also be a violation of that obligation. It is not clear which case would have worse consequences (Begley 1987). It seems that these possibilities must be strictly guarded against in any payment arrangement.

The argument may also be made that one payment system may better protect patients against clear violations of the physician-patient obligation. Morreim and Relman argue that patients are better able to protect themselves against the biases of FFS than those of CPP. Further, the uncertainties of the benefits of medical treatment require that payment mechanisms encourage greater service. Morreim writes that a patient can more easily identify an unnecessary treatment which is being offered than they can identify a necessary treatment which is being withheld:

Here the unethical physician would garner his extra revenue, not from recommending that which is not needed, but from not recommending that which is needed. His tool is silence, rather than persuasion. And the patient may never realize that potentially beneficial options are being denied to him. He is poorly situated even to consider obtaining another opinion (Morreim 1985).

Moreover, Morreim argues that since patients are used to the fact that physicians usually are paid for each procedure performed, they are used to being more suspicious about proposed treatments that do not appear to be
useful.

However, Begley responds that there is no evidence that the above is true. Furthermore, one is just as likely to seek a second opinion for any treatment plan which does not sound appropriate -- whether it is over or undertreatment (Begley 1987).

In summary, there does not appear to be conclusive evidence that (1) the incentive to inappropriately undertreat is stronger that the incentive to inappropriately overtreat or, (2) the consequences of inappropriate undertreatment are worse than those of inappropriate overtreatment. Thus, the potential for abuse is inherent in the nature of the physician/patient relationship; these abuses must be protected against regardless of the payment mechanism.

Capitated Prospective Payment in the Health Plan of San Mateo

We now turn away from the arguments against CPP generally and look specifically at CPP in the Health Plan of San Mateo (HPSM), employing the criteria for justice developed by Fleck (1987).

With respect to impartiality, CPP is biased toward reducing treatment in a manner similar to that which FFS is biased toward increased treatment. As we have seen, there is no evidence which supports the idea that CPP is more heavily biased in the negative direction than FFS is biased in the positive.

However, the pressures on the primary care provider may be different in the two systems. In FFS, the incentive to overtreat is not that great for the primary care provider because of the poor reimbursement level for an office visit. Under capitation, there is a strong incentive to undertreat, particularly for very sick or time consuming patients. It appears that the
bias against less healthy patients may be stronger in a CPP plan than in a FFS one.

The procedures and policies of a public health plan should be open and accessible to public scrutiny. The provisions of the HPSM are open to all members of the public and open Commission meetings are held each month in San Mateo to discuss Health Plan policy. In this respect, HPSM policies have been brought closer to the public than the FFS Medi-Cal program.

The procedures and policies of the health plan should demonstrate respect for participants as free and equal persons. The program has a Consumer Advisory Group which meets monthly and may bring issues of concern to the Commission. Day care and transportation expenses are reimbursed for Advisory Group members who are single mothers and would otherwise not be able to attend.

However, there is the concern that under capitation, those who are more sick may not be treated as well as the less sick. Physicians may be inclined to discourage sick patients from remaining in their practice since the capitation payment may not adequately reimburse them for their care. Additionally, because these patients require more treatments, sicker patients may more likely be the focus of a treatment denial than a less sick patient. Moreover, patients seeking care at the end of the month may receive less comprehensive care if the physician knows that he has already provided much more care this month than he has been compensated for.

In contrast, under FFS, patients whose required treatment is poorly compensated may not receive it. Patients may also receive unnecessary treatments which are well compensated. However, these risks are distributed more evenly throughout all patients than under CPP and the incentives do not vary greatly from provider to provider. Further, the beginning versus end of
month treatment variation is not likely. Thus, it is possible that CPP may not fulfill concerns of respect for each individual as free and equal persons as well as a FFS plan.

Next, we consider whether or not the HPSM provides for fair terms of cooperation. As the survey results demonstrated, many primary care physicians argue that CPP places too high a financial responsibility upon their group. It is not clear that primary care physicians should be financially responsible for the health care of their patients. For example, patients may disregard prescribed therapy and thus require repeated office visits. Moreover, Medicaid was created as a national program because it was felt that all of society should share the burden of providing care to those that could not afford it. Why should the burden be placed disproportionately upon primary care case managers?

The argument for why that burden be should be shifted to primary care physicians (PCP’s) disproportionately compared to other physicians or even other individuals in the society is that they are the gatekeepers to the system. However, a compelling argument has not been made for the notion that it is appropriate for PCP’s to hold financial responsibility. The only argument put forward is one of practicality which says that the economic incentive is the only way to change physician behavior. Regardless of whether or not this is true, it is not at all clear that CPP has created fair terms of cooperation between society and the providers of health care. In giving PCPs this added responsibility, this mechanism has placed an additional consideration, macroeconomics, within the context of the physician patient relationship.

Under FFS, society is financially responsible for all of the health care of the poor. If society decides that they are paying too much for Medicaid,
they can limit coverage or benefits. Moreso than under capitation, decisions are reached in an open forum -- not individually in the offices of practicing physicians.

Next, we address the issue of stability over time. It has already been discussed that throughout a month, a patient may receive varying treatment depending on how that PCP is doing on his capitation ledger. Furthermore, if one physician tends to have sicker patients, currently there is no additional compensation given. These patients may receive less comprehensive care if the physician is constantly losing money.

Moreover, the capitation rate is based on an average patient for the previous year. Should a physician be approaching each patient as a challenge to keep his care close to the average? Patients often do not present as average cases. This may result in greater variation in patient treatment between physicians than under FFS.

There was an incentive to undertreat also in the FFS system as physicians were not compensated adequately for the work involved. However, this incentive did not vary throughout the month. Additionally, this incentive was the same for each patient needing that specific treatment.

Overall, there are serious concerns in the CPP systems that treatments may not be consistent over time. It appears that this potential is lower in FFS systems.

Is the CPP system strategy consistent with findings of the best methods of inquiry available in society? Prospective payment has been shown to reduce medical expenditures. However, while many studies show no difference in health care status in FFS vs. CPP, more studies are emerging suggesting a difference in quality of health care. One study has also shown that there may be a decrease in quality of care in less educated patients with severe medical
conditions (Ware 1986). Moreover, a recent study of the care of elderly with hip fractures demonstrates that while length of stay declined under prospective payment, the quality of care was lower and fewer physical therapy sessions were given. This resulted in poorer ambulatory abilities and less return to normal function one year after surgery (Fitzgerald, Moore & Dittus 1988).

It is likely that prospective payment is the best tool available to reduce medical expenditures, however institutional modifications, to be discussed later in this chapter, may be necessary to insure quality of care.

Lastly, does the HPSM strike a reasonable balance among competing views of justice? By attempting to reduce society’s allocation of resources toward unnecessary treatments, this strategy addresses utilitarian concerns. Prima facie, CPP appears to contain aspects of egalitarianism, however, we have shown that this payment mechanism may increase the variation in treatment that patients receive. CPP does address libertarian concerns as the government’s role in mandating Medicaid treatment policy is reduced. However, from a contractarian point of view, it seems unlikely that all the players in this system would have agreed upon a system structured in this way, as compared to FFS.

**Improvements to the current CPP system**

Data explored earlier explaining the savings associated with HMO’s suggest that prospective payment seems to be the most practical approach to cost containment available today (Luft 1981). However, certain modifications would need to be made for this to be a social improvement, from an ethical perspective. First, patients should be informed of the incentives under which
their physician is practicing. Patients understand the FFS system and currently may be more likely to question a treatment which sounds unnecessary than one which they think is necessary. If patients understand that their physician may be profiting from denying treatment, they may be more likely to desire a second opinion for a physician's decision not to treat (Levinson, 1987).

Second, patients should always have a mechanism for second opinions. Under the current system, a patient is "locked in" to a specific provider and cannot receive care without permission from the PCP. Furthermore, the patient cannot opt out of the capitated system if they feel that their needs are not being met. It is imperative that policy be implemented that requires the PCP to give authorization for a second opinion at the patient's request.

Third, protocols describing norms of care for particular ages, diagnoses and patient populations should be made part of the program. This would help to reduce the variation in medical treatment. This would give PCP's guidelines about their responsibilities as case manager and make it more difficult to undertreat at their own discretion. This would reduce concerns about varying quality of care amongst physicians and throughout a given month. This would aid in the quality assurance review process. Moreover, this would minimize the amount of social decision making that PCPs have to make and allow them to focus more closely upon their obligation to the patient, given the restrictions imposed by the guidelines.

Fourth, global decisions regarding the norms of care should be discussed in the larger social sphere. This would remove the PCP from having to make global allocation decisions. Physician input would consist of data regarding the efficacy and cost-effectiveness of treatment plans. This would make the process more publicly discussed and would encourage a balance between the
competing conceptions of justice in the society. Moreover, this would encourage the pooling of information regarding the efficacy of treatments and reduce regional variation. Policy would be made with open discussion of medical, political, economic and social concerns rather than in the individual practitioner’s office where the decision may be made based on his standing during that particular month on the capitation ledger.

Some have stated that the above requirements would be costly and not easily attained. It is the opinion of the author that these are the costs that must be paid in order to achieve economic goals without bankrupting our moral concerns. The issue of quality assurance is just as important in CPP as in FFS. If, in fact, the price it too high to pay, perhaps the solution is make modifications within the FFS system.

Remaining Problems

Even with the above reforms, the problem of penalizing physicians who have sicker patients would still persist. Adjustments to the capitation rate could be made, but this increases the complexity and administrative costs of the program. One gets to the point where each person would need an individualized capitation rate and now we are basically back to FFS. Encouraging physicians to have >150 patients would reduce the likelihood of adverse selection to reasonable levels, but few physicians would agree to that number. Only 63 of 250 case managers in the HPSM have >50 patients in their practice (HPSM data, March 1989).

Also, the problem of primary care physicians being financially responsible for health care would still remain. To address this concern,
capitation payments could be made only on the institutional level, eg. to an
HMO, or health insuring organization (HIO). The HMO or HIO would have an
incentive to provide strong physician education and penalty programs regarding
the protocols. Physicians would be paid for procedures performed within the
guidelines. The potential for overtreatment would still exist; however, it is
minimized by 2 factors: (1) the protocols which describe norms of care; and
(2) the HIO budget which would be limited to the capitated rate received from
the state program.

It appears that a FFS system, with the use of protocols, would address
our concerns better than a capitated system. The large difference is that the
capitated system asks the physician to look at each patient as an average and
it may not be possible to treat the patient according to the protocol for that
average cost. Here we force the physician, within the context of his
relationship with the patient, to shoulder the financial responsibility of
higher levels of disease in his patients. While the use of protocols would
alleviate the problem of physicians making societal decisions about allocation
priorities, under capitation the physician is still in the position of
suffering financial losses due to factors outside his control.

The FFS approach is more straightforward, and would avoid the
inappropriate shift of financial responsibility for the health of society away
from society and onto the physician. Physicians who consistently practiced
inappropriately on the high end of expense could be identified, counselled and
their participation in the program restricted if they did not comply with the
protocols. If costs under this system are still higher than society wishes to
pay, then society as a whole must decide how to restrict services allowed by
the protocols. The important issue is that these decisions will be made with
political, economic and social concerns in mind, along with the help of
medical advisory panels.

Restricting services under prospective payment can result in reduction of quality of care as the study of hip replacement surgery in the elderly demonstrated (Fitzgerald, Moore & Dittus 1988). We must ask ourselves the question, "Is this really the will of society?" Would, for example, society prefer to make the requirements for organ transplantation more stringent and perhaps allocate more funds for physical therapy for the elderly?

The point is that currently, we do not know. Individual practitioners are forced to make individual decisions about allocations of the huge wealth of medical resources, which are owned by society -- not physicians. And they must do this within the context of a physician patient relationship. This leads to inconsistent decision making without explicit goals. Success is measured solely on the parameter of decreased costs. The use of societally developed protocols in a FFS system will provide the goals that are currently lacking and will not punish providers for treating patients that are ill.

CONCLUSIONS

Physicians have been thrown into an arena of cost containment from which a graceful exit will not be possible. Social and political factors discussed in Chapter II of this paper led to efforts at reducing both expenditures on Medicaid and the professional authority of the physician. Providing economic incentives to reduce costs may be an effective and ethical approach to cost containment; however, capitation should not extend into the physician patient relationship, because this shifts the financial responsibility of health care from the society into the physician's office.
Society has the responsibility to set priorities and develop guidelines for care which incorporate medical standards of care, social concerns, economic factors and political realities. It is then the role of the physician to implement the guidelines within the context of his or her relationship with the patient. In this relationship, the physician acts as the patient's advocate to assist in achieving the best care, within the limits of the socially accepted guidelines. In this way, cost containment strategies may be implemented within the health care system and minimize the degree to which the individual physician must make social decisions in every patient encounter.
CONCLUSION
Medicaid, as a program to bring health care to the poor, has been successful. The differential in patient visits for lower income families compared to upper income families has been dramatically reduced from what it was in the early 1960's. However, the cost of this success has been higher than had been anticipated. The current search for viable strategies for cost-containment has evolved from roots in the 1970's when the combination of inflation and economic recession caused rapidly rising rates of medical expenditures that outpaced the growth in state and federal revenues.

In the 1980's, capitation and competition have been embraced as a new way of thinking about health care. Today, financial incentives for physicians to do provide fewer services have become commonplace, yet there is little data regarding how these policies affect physician decision making and patient satisfaction. This paper has examined the effects of a capitated managed care program in Medicaid with respect to physician attitudes and behavioral changes.

It has been demonstrated that the large scale dramatic changes needed to curb the growth of health care spending have not occurred in the Medicaid experimentation projects. The survey results discussed in Chapter V suggest that part of the reason is due to the lack of clear guidelines of what case management is and how this impacts upon the physician/patient relationship. It appears that any cost savings that occur are primarily the result of restricting patients' access to care -- not because of changes in physician behavior leading to coordiated health care with an emphasis on preventive medicine. Furthermore, physicians with sick patients in their practice may lose financially. These losses occur not because these physicians are misusing the health care system, but because they are paid a flat rate which
does not recognize the fact that most health care costs are attributable to a relatively small number of patients.

Capitated payment mechanisms present serious ethical concerns which were outlined in Chapter VI. In light of the fact that the financial incentives to physicians have not had much of an effect overall in changing behavior, it seems that the costs of capitated payment may outweigh any potential benefits. Instead, the case management function should be developed more fully, with clear and specific guidelines attached. These guidelines for care should include societal priorities for the allocation of health dollars so that these decisions are not left for each individual physician to make on his or her own. Furthermore, capitation should be replaced with a strongly monitored fee-for-service mechanism in which preventive medical services are well rewarded and the unnecessary use of specialists and emergency rooms is penalized.

Ultimately, medical care is expensive. As a society, issues of distributive justice must be discussed in a public forum, so that priorities can be identified and fostered. Simply allowing cost-containment to occur by placing primary care physicians at financial risk does not fulfill the ethical or social demands of physicians or their patients.
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