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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

RONALD REAGAN, Governor

DEPARTMENT OF HEALTH
714-744 P STREET
SACRAMENTO, CALIFORNIA 95814

Molly

October 18, 1974

Honorable Ronald Reagan
Governor of California
State Capitol
Sacramento, CA 95814

Dear Governor Reagan:

In accordance with the Welfare and Institutions Code, Section 14320, we hereby submit the Department of Health's Annual Report on Prepaid Health Plans (PHPs).

Respectfully,

Original Signed By
DAVID A. WINSTON

William Mayer, M.D.
Director of Health

Attachment

bcc:Health and Welfare Agency
Governor's Office ✓

Same letter sent to addresses on attached list.

Same letter sent to addresses listed below:

Honorable Ronald Reagan
Governor of California
State Capitol
Sacramento, CA 95814

Honorable James R. Mills
President Pro Tempore
State Capitol
Sacramento, CA 95814

Honorable Leo T. McCarthy
Speaker of the California Assembly
State Capitol
Sacramento, CA 95814

Honorable Anthony C. Beilenson, Chairman
Senate Health and Welfare Committee
State Capitol
Sacramento, CA 95814

Honorable Henry A. Waxman, Chairman
Assembly Health Committee
State Capitol
Sacramento, CA 95814

Honorable Randolph Collier, Chairman
Senate Finance Committee
State Capitol
Sacramento, CA 95814

Honorable John F. Foran, Chairman
Assembly Ways and Means Committee
State Capitol
Sacramento, CA 95814

State of California

Department of Health

Memorandum

2.2595

To : Thomas J. Elkin
Assistant to the Secretary, Legislation
Health and Welfare Agency
915 Capitol Mall

Date : August 26, 1974

Subject : Annual Report to the Governor and Legislature on Prepaid Health Plans (PHPs)

From : Office of the Director

Attached are copies of the Annual Report to the Governor and Legislature required by Section 14320 of the Welfare and Institutions Code. Upon approval and release to the Governor and Legislature, please notify me so that the Department may comply with requests from the public for copies.

ORIGINAL SIGNED BY: JIM FOSSUM

James Fossum
Executive Assistant to
Director of Health

Attachment

bcc:Governor's Office ✓

ANNUAL REPORT TO THE GOVERNOR AND LEGISLATURE ON PREPAID HEALTH PLANS (PHPs)

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH – JUNE 1974

Annual Report to the Governor and Legislature on Prepaid Health Plans (PHPs)

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INTRODUCTION

Efficient and effective delivery of quality health care services is a goal vigorously pursued by federal, state, and local governmental agencies, organized labor, employer/employee groups, business interests, community action programs, and private citizens. Health care services -- cost, quality, availability, and proper use -- have become of vital concern to administrators, legislators, taxpayers, and consumers alike.

The Medi-Cal program, providing for health care services to over two million eligible Californians, has continuously sought innovative ways to manage the cost, utilization, and quality of the services delivered under the program. Since 1968, the Department of Health has entered into pilot projects to study the feasibility of various methods of delivering services, managing their utilization, and controlling program costs.

Based upon departmental experience with a number of those pilot projects, Medi-Cal Reform Plan legislation (Assembly Bill 949, Chapter 577, Statutes of 1971, operative October 1, 1971) included provisions which authorized the Department to enter into prepaid health plan (PHP) contracts. A PHP is an organization that contracts with the Department to provide a broad scope of health care benefits delivered to enrolled eligible Medi-Cal beneficiaries on the basis of a predetermined periodic capitation rate. Public assistance Medi-Cal beneficiaries residing in the service area of a PHP have the option of enrolling in a PHP to obtain necessary medical services. Those who do not voluntarily select the PHP option

continue to receive their medical care through the traditional fee-for-service health care delivery system.

The scope of benefits offered by PHPs must include, as a minimum, physician services, hospital outpatient services, laboratory and X-ray services, prescription drugs, hospital inpatient care and skilled nursing facility care. The Department has fostered a policy requiring a comprehensive scope of benefits be delivered by each PHP.

The Waxman-Duffy Prepaid Health Plan Act (Assembly Bill 1496, Chapter 1366, Statutes of 1972, operative July 1, 1973) expanded the Department's administrative authority and duties regarding PHPs, enumerated additional PHP participation standards, and established conflict of interest provisions regarding PHP contracts. The Waxman-Duffy Prepaid Health Plan Act also requires that the Department "report annually to the legislature on the contracts made under this act...".

The first PHP contract, effective May 1, 1972, was written to provide a comprehensive range of Medi-Cal services to a potential of 20,000 enrollees in South Central Los Angeles. By the end of 1972, 20 more contracts had been entered into to provide services to a potential of 380,284 enrollees in Los Angeles, Sacramento, El Dorado, Nevada, Placer, Yolo, Orange, San Bernardino, Santa Clara, San Diego, and Riverside counties. By the beginning of the 1973-74 Fiscal Year, 46 PHP contracts were in existence to provide services to a maximum of 795,984 enrollees in the counties cited above plus Ventura, San Francisco, and San Mateo. The actual number of persons enrolled in PHPs on July 1, 1973, was 178,372.

By July 1973, the Department had signed a sufficient number of PHP contracts in certain geographic areas, most notably Los Angeles, Orange, and San Diego counties, to offer the PHP alternative to almost any public assistance Medi-Cal beneficiary who elected to enroll in a PHP. Because of the large number of existing PHPs in these counties, low priority was given by the Department to new proposals from these areas. Conversely, a high priority was assigned to proposals from other counties, especially in Northern California. Consequently, the first part of the 1973-74 Fiscal Year saw the development of PHP contracts in Alameda, Contra Costa, Kings, and Tulare counties. As of March 1, 1974, the potential enrollment for all PHPs was 865,200; the actual enrollment was 226,669.

This annual report presents information on the following aspects of the PHP program: physician/patient ratios; Medi-Cal beneficiary/private patient enrollment ratios; enrollee satisfaction; and the quality, utilization, and cost of services.

The time period covered in this annual report is July 1973 to June 1974. The next annual report on PHPs will be issued in January 1975 and will cover the time period from the issuance of this report to the end of the calendar year 1974. Thereafter, each annual report on PHPs will cover the calendar year immediately preceding its issuance.

PHYSICIAN/PATIENT RATIOS

The initial entry point in a health care delivery system is usually through a physician. Prescription drugs, hospital or nursing home admittance, referrals to specialty providers like physical therapists, psychologists, dispensing opticians, and durable medical equipment suppliers are made by physicians. There are physicians in a variety of specialty practices -- urology, otolaryngology, radiology, ophthalmology, and neurosurgery, to name a few -- whose services are usually obtained through referral by a person's family physician.

Family physicians, pediatricians, internists, obstetricians/gynecologists, and general surgeons are referred to as primary care physicians. Primary care physicians are responsible for the basic health care of almost all Americans. Since one of the main objectives of the PHP program is to provide enrollees with ready access to mainsteam medical care, the primary care physician is the keystone of any PHP.

The Waxman-Duffy Prepaid Health Plan Act requires, as a minimum, that each PHP must have a core of five primary care physicians, including a pediatrician, obstetrician/gynecologist, internist, and general surgeon, and that a full-time primary care physician be available for every 1,600 enrollees in the PHP. All PHPs are reviewed periodically to assure compliance with this requirement.

The following table presents the primary care physician/Medi-Cal enrollee ratios and the primary care physician/total patient caseload ratios for

PHPs as a whole. Total patient caseload includes Medi-Cal enrollees, Medi-Cal fee-for-service patients, private enrollees and private fee-for-service patients receiving medical care through a PHP.

Number of Patients Per Each PHP Primary Care Physician

	July 1973	September 1973	December 1973	March 1974
Medi-Cal Enrollees	410	480	404	393
Total Patients	1,074	1,413	1,123	1,110

MEDI-CAL ENROLLEE/PRIVATE ENROLLEE RATIOS

One way to insure that PHP enrollees are receiving access to mainstream medical care is to require PHPs to provide prepaid health benefit packages to members of the general public. The Waxman-Duffy Prepaid Health Plan Act requires each PHP to make all reasonable efforts to attain by its third contract year an enrollment of not more than 50 percent Medi-Cal beneficiaries.

In July 1973, the total subscriber population of all PHPs comprised 25.1 percent private enrollees; in March 1974, it comprised 30.6 percent private enrollees. For second-year PHPs, the percent of their total subscriber population consisting of private enrollees was 24.0 for July 1973 and 32.9 for March 1974. The steady increase in private enrollments in second-year PHPs over this time period is indicative of the efforts being made to comply with the intent of the Waxman-Duffy legislation.

Enrollment data from PHPs operated by Kaiser-Permanente is not included in these calculations due to the fact that the size of Kaiser's private enrollee population would skew the ratios beyond any point of reasonable interpretation.

ENROLLEE SATISFACTION

Satisfaction of a consumer population with a particular product or service has long been an indicator of worth and quality of that item. Products, for the most part, can be objectively evaluated using data on useful life of the product, frequency of required maintenance or repairs, replacement cost, etc. Services are not as conducive to the same criteria for evaluation as are products, although some services can be measured fairly accurately as to quality and reliability.

Health care services are especially difficult to evaluate for a complex series of reasons, among the more significant ones:

1. Standards for an objective assessment of quality of care are still in the developmental stage, being almost nonexistent within traditional medical practice until the late 1960s; and

2. The doctor/patient relationship goes beyond the traditional buyer/seller relationship; it is a privileged, confidential communication on a most personal subject -- a person's physical and mental well-being.

However, effective health care treatment does depend in part on the doctor/patient relationship. Although most patients are not technically qualified to judge the appropriateness or quality of the medical care they receive, the patient's trust in, and satisfaction with, his physician is an integral ingredient in the provision of health care services. To

determine whether enrollees are satisfied with the health care they are receiving from PHPs, the Department is using three types of input from enrollees:

1. The number of voluntary disenrollments every month;

2. Complaints received from PHP enrollees; and

3. The PHP Beneficiary Satisfaction Survey conducted and tabulated by the Department.

The monthly voluntary disenrollment rate reflects the number of persons disenrolled from PHPs, for reasons other than loss of eligibility, in relation to the number of persons enrolled in PHPs for a particular month. The monthly voluntary disenrollment rate is a negative measure of enrollee satisfaction. It primarily indicates the percent of persons sufficiently dissatisfied with PHP services to wish to obtain their medical care through the fee-for-service delivery system.

As shown in the following table, the monthly voluntary disenrollment rate has steadily decreased in the last year. For the first four months of 1974, the composite monthly voluntary disenrollment rate was 1.15 percent.

Number of Voluntary Disenrollments Per 100 Enrollees

May 1973	August 1973	October 1973	December 1973	March 1974
3.56	2.42	2.31	2.06	1.20

The decrease in the monthly voluntary disenrollment rate can be primarily attributed to departmental verification of PHP enrollments. In October 1973, after a careful evaluation of each PHP's marketing activities, the Department instituted a process whereby all enrollment applications from PHPs in Los Angeles, Orange, and San Diego counties were submitted to the Los Angeles Information Office for verification.

Verification of enrollment applications entails contacting the applicants, soliciting information about the content and circumstances of the enrollment presentation and PHP follow-up, and affirming that the applicant did, in fact, make an informed voluntary decision to enroll in the PHP. If clearly affirmative response is not obtained, the enrollment applications are returned to the PHP so that the beneficiary may be supplied with further information necessary to make an informed, voluntary decision regarding enrollment. If potential enrollment misrepresentation or fraud is uncovered during the verification of an application, these applications are referred to departmental investigative personnel for appropriate action.

Verification of enrollment applications has substantially reduced the voluntary disenrollment rate. The extent to which a potential enrollee is informed and has an appropriate expectation of the PHP has an impact on his satisfaction with the services he receives after his enrollment. The ability of the PHP to effectively meet the health needs of the enrollee as he perceives them also impacts the enrollee's satisfaction with the PHP.

One way the Department evaluates such satisfaction is by monitoring enrollee complaints. Like the monthly voluntary disenrollment rate, complaints are a negative indicator of enrollee satisfaction with PHPs; persons not registering complaints are assumed to be at least nominally satisfied with their PHP.

Enrollee complaints are lodged with the PHP directly, the Department, the person's legislative representatives, eligibility workers, county welfare departments, medical societies, and other public and private agencies. The vast majority of complaints are lodged with, or referred to, the Department's Los Angeles Information Office. This office, among its several duties pertaining to the PHP program, investigates complaints received and assists in resolving matters of misunderstanding or misinformation.

Complaints involving possible misrepresentation or fraud, and those involving the quality of care provided by a PHP, are referred to departmental investigative personnel for research and appropriate action.

Complaints Referred for Investigation by the Los Angeles Information Office

Complaint Subject	July 1973	September 1973	November 1973	January 1974	March 1974
Quality of Care	11	14	7	17	10
All Other Reasons	63	57	52	27	24

The noticeable decrease in the number of these complaints, during the same time period in which total PHP enrollments increased 27 percent, is attributed to the Department's enrollment verification efforts and to

closer contract management made possible by the legislatively approved staff augmentation in December 1973.

The PHP Beneficiary Satisfaction Survey is the positive indicator that the Department uses to assess enrollee satisfaction with PHPs. This survey compares responses to questionnaires mailed to enrollees of selected PHPs in relation to the responses to parallel questions asked of a control group of fee-for-service Medi-Cal beneficiaries residing in the same geographic area. Responses are tabulated for each individual PHP and for the aggregate of all the PHPs surveyed.

The Department surveyed enrollees of 14 PHPs and fee-for-service Medi-Cal beneficiaries in Los Angeles, Orange, San Diego, San Bernardino, and Santa Clara counties during March and April 1973. The following table displays responses to various questions asked of both groups in the survey.

Responses to Beneficiary Satisfaction Survey

	PHP Enrollees		Control Group	
	Number	Percentage	Number	Percentage
Questionnaires sent	8,202	--	4,021	--
Returned	2,627	32.0	1,301	32.4
Should have gone to doctor but did not	1,213	46.2	521	40.1
Could get an appointment when wanted	2,113	80.4	1,115	85.7

	PHP Enrollees		Control Group	
	Number	Percentage	Number	Percentage
Waiting time to see doctor				
20 minutes or less	902	34.3	605	46.5
40 minutes	844	32.1	388	29.8
60 minutes or more	881	33.5	308	23.6
Sufficient seating space in waiting room	2,099	79.9	1,143	87.9
Staff usually pleasant	2,471	94.1	1,271	97.7
Received care went for	2,226	84.7	1,223	94.0
Happy with care received	2,003	76.3	1,161	89.2
Doctor really interested in patient's health	2,129	81.0	1,143	87.9
Distance traveled for medical care				
1-8 blocks	500	19.0	209	16.1
9-16 blocks	469	17.9	251	19.3
17 or more blocks	1,657	63.1	841	64.7
Gone to non-PHP doctor (includes emergency services)	500	19.0	not applicable	

Although the control group beneficiaries responded to the same questions with a generally larger percentage of positive responses, there was a

significant enough variation for only three items to indicate areas in which PHPs could improve performance. First, PHP enrollees indicated that they should have gone to the doctor but did not substantially more than fee-for-service beneficiaries. Second, PHP enrollees stated they wait longer to receive medical care than fee-for-service beneficiaries. Third, a smaller number of PHP enrollees are happy with the care they are receiving than are fee-for-service recipients. However, this response seems slightly anomalous since their other responses indicate they received the care they sought and they thought the doctor was really interested in their health.

The Department is not thoroughly satisfied with the effectiveness of its survey instrument. To obtain more precise results in assessing enrollee satisfaction, the Department is working to revise the content and format of the PHP Beneficiary Satisfaction Survey to remove, as much as possible, any inherent bias and to achieve the greatest possible amount of reliability in the data.

QUALITY OF CARE

Quality of care is, by far, the most difficult component of any health care delivery system to assess. The fee-for-service delivery system uses evidence of provider licensure and certification, and local peer review processes, to attempt assessment of the quality of medical care provided. In monitoring the quality of care provided by PHPs, the Department uses the same types of information that the fee-for-service system applies to quality assessment and also adds medical surveys to PHP quality evaluation processes. The medical survey approach is composed of three separate processes -- the precontract survey, the periodic medical survey, and special follow-up medical surveys when deemed necessary by any one of the medical review team members.

The precontract survey assesses the potential capacity of the proposed PHP to deliver the range and scope of Medi-Cal services specified in the contract. The review is conducted by an experienced Medi-Cal field representative, with the assistance of a departmental medical professional if necessary. The Medi-Cal field representative reviews the proposed PHP's staff and facilities. A departmental medical professional reviews the precontract survey and sends the information, along with his recommendations, to the Department's Health Plans Operation Section, which is responsible for developing and approving the PHP contract.

Periodic medical surveys of PHPs are conducted after the third and ninth months of contract operation. A survey team consisting of a physician, a

dentist, a pharmacist, and a field representative review services, equipment, and records at the PHP facility. The field representative reviews required licenses and certificates of operation and inspects the facility and its equipment. The physician and field representative scan facility medical records and review in detail a sample of these records. The sample size is proportionate to number of PHP enrollees. Completeness, legibility and organization of the medical record, evidence of preventive care, history, physicals, and follow-up visits and adequacy of diagnosis and treatment are given special attention in the medical record review.

At the conclusion of the periodic medical survey, the team conducts an exit interview with the medical director of the PHP and the departmental contract manager to discuss the survey findings. The physician team leader informs the plan and the contract manager of all deficiencies found and establishes a time period in which corrective action must be taken. Close contact among the contract manager, the PHP, and the Department's Quality Evaluation Section is maintained regarding what action has been taken to rectify problems and deficiencies uncovered in the periodic medical survey. The team then verifies these corrections during the next periodic medical survey.

Serious deficiencies uncovered in the periodic medical survey require immediate corrective action. In some cases corrective action must be undertaken before the completion of the survey itself. Details of the nature of the corrective action are presented to the survey team; and, if necessary, a follow-up medical survey is scheduled. The purpose of this survey is to inspect first-hand the corrective action taken on

serious deficiencies and to determine if that action taken was appropriate. Deficiencies which pose a threat to the health or welfare of patients or PHP personnel are resolved during the exit interview.

A limitation of the medical survey approach to quality of care assessment is that it does not produce data upon which comparative studies of PHPs can be based. The medical survey approach is an evaluation of care in relation to a set of primarily subjective standards (e.g., the reviewing physician's evaluation of the appropriateness and completeness of an individual treatment pattern for an isolated case, as reflected in the patient's medical record). The objective measurements used in this process are similar to those used throughout the traditional health care delivery system. These are determinations that a particular PHP has met a specified set of standards (e.g., facility and provider licensure and certification, amount of waiting room space to patient caseload, etc.). They provide a reasonable expectation that quality care will be provided in PHPs as they do in the fee-for-service delivery system.

The medical survey approach provides the Department with concrete indications that the quality of care in a particular PHP is of an acceptable level to allow the PHP to continue providing services to its enrollees.

The Department has entered into a contract with Interstudy of Minneapolis, Minnesota, to assist the Department to develop and implement new techniques for refining the definition of, and evaluating, the quality of care in PHPs and to develop a health status measurement system to assess the effects of PHPs on the health status of their enrollees.

Interstudy is a firm nationally reputed for its work in the assessment of quality of care. The money used in this endeavor was appropriated by the Legislature as a special item in the 1973-74 budget to enable the Department to study the quality of care in PHPs.

The main purpose of these new techniques will be to assess the results or "outcomes" of health care services provided by PHPs. They will measure the outcome of the treatment of a specific diagnosis, disease entity, or injury against outcome criteria previously established by the Department for PHPs in that community. Nonphysician personnel will abstract and display medical records which do not reflect clinical practice of the previously established outcome criteria. This process will permit the evaluation of a substantial number of cases and requires physician time only in evaluating the cases which deviate from the established outcome criteria. Professional personnel will evaluate the deviating cases to determine if there is a clinical justification for the deviation and, where no adequate clinical justification is present, to determine the necessary corrective action that must be taken by the PHP.

Should the outcome measurement approach prove workable for the PHP program, its implementation will allow the Department to gather objective data which can be used to compare quality of care among the several PHPs within the same geographic location. At the same time, the present medical survey process will continue to collect information on the processes involved in the delivery of care in each PHP. The use of both types of assessment will enable the Department to evaluate quality of patient care on two inseparable components of care -- process and outcome.

UTILIZATION OF SERVICES

The primary goal of every health care delivery system is to provide medical services to persons requiring health care. Assessment of whether a particular health care delivery system has provided a sufficient amount of appropriate medical care to meet the needs of the persons it services is the measurement of that system's effectiveness. Effectiveness is measured by evaluating several aspects of the services provided. Accessibility, quality, and scope and duration of services must all be considered in a proper evaluation of system effectiveness.

For the PHP program, accessibility to services is assessed by evaluating PHP Beneficiary Satisfaction Survey responses dealing with availability of appointments, seating space, length of waiting time, distance traveled to obtain services, and the like. Quality of care is assessed through the periodic medical survey process and investigation of enrollee complaints. Evaluation of the scope and duration of services provided is accomplished through an analysis of the utilization rates of specific services.

PHPs are required to submit to the Department on a monthly basis a tabulation of medical services provided to enrollees. This gross data is refined to determine the number of specific services provided to every 1,000 enrollees. Rates of utilization for specific services are developed for all PHPs on individual and aggregate bases.

The table below presents aggregate utilization data for selected services for the months of July and October 1973 and January 1974. Figures represent the number of services given per 1,000 enrollees in the PHP program.

PHP Utilization Rates for Specific Services Per 1,000 Enrollees

Service Type	July 1973	October 1973	January 1974
Physician Services, Outpatient	327.0	346.6	274.1
Physician Services, Inpatient	37.2	44.1	30.9
OB Care	3.1	4.1	2.8
Urinalyses	26.0	24.0	23.6
Immunizations	18.8	21.8	16.4
Consultations	8.3	10.5	7.8
Blood Counts	27.8	29.7	31.6
Electrocardiograms	6.7	5.4	4.7
Chest X-Rays	12.3	14.0	12.6
Prescription Drugs, Outpatient	354.9	396.9	437.4
Hospital Admittances	6.4	6.3	7.8
Inpatient Drugs	33.0	36.3	29.7
Hospital Visits, Outpatient	6.9	6.3	18.0
Hospital Inpatient Days	28.7	46.0	30.7
Dental Visits	38.8	47.5	38.6
Number of Dental Procedures	77.6	93.1	79.5
Nursing Home Admittances	0.3	0.7	0.2

Service Type	July 1973	October 1973	January 1974
Nursing Home Inpatient Days	8.4	21.4	6.4
Optometric Visits	9.6	12.2	19.9
Ophthalmology Visits	2.0	3.6	4.1
Eyeglasses Provided	6.1	7.6	9.9
Home Health Agency Services	1.7	3.0	1.0
Physical Therapy Visits	7.1	8.0	6.5
Psychology Services	2.2	4.0	2.6
Lab Procedures	114.5	120.1	105.0
X-Ray Procedures	34.2	42.9	31.0

Before any meaningful comparisons can be made of fee-for-service and PHP utilization statistics, it is requisite to collect, evaluate, and control for such demographic variables as age and sex distribution and geographic location of the populations under comparison.

The Department has been trying to solve problems attendant upon the reporting, compiling, and comparing utilization data from PHPs. Efforts are being undertaken to revise the data reporting requirements and format so that more reliable and useful data is collected from each PHP, along with appropriate demographic data. In-depth comparative studies of utilization of services in PHPs and the fee-for-service delivery system may then be initiated.

Comparative analysis of the variation in the utilization rates for specific services between nonprofit and for-profit PHPs, as determined by their

registration documents filed with the Attorney General, for January 1974 reveals that for-profit PHPs (these must be for-profit medical organizations according to the Medical Practices Act) provide significantly more physician services, than do nonprofit PHPs. Nonprofit PHPs, however, provide significantly more consultative services and prescription drugs than do for-profit PHPs. Both types of PHPs provide comparable levels of nursing home care, vision care services, and obstetric care. To discover the causes of these differences, complete demographic data for both types of PHPs will have to be compiled and analyzed.

COST OF SERVICES

Cost is a determining factor in the success of any program, especially so in programs dealing with the expenditure of public monies. A program's effectiveness -- how well it accomplishes its objectives -- is always measured in relationship to its efficiency -- how much money it costs to attain the program objectives.

To continue in operation, the PHP program must show that its objective, to provide access to mainstream medical care to enrollees by shifting the burden of utilization control and fiscal management from the Department to the providers of service, was attained through a judicious use of public funds.

The Waxman-Duffy Prepaid Health Plan Act requires that the cost of providing services to PHP enrollees be no more than the cost of providing comparable services through other health care providers; namely, through the fee-for-service delivery system. To insure that this provision of law is adhered to, the Department uses projected fee-for-service expenditure for the appropriate geographic locale, minus a percentage savings factor, as the basis for the negotiation of PHP rates. Rates vary depending on the geographic location of the PHP and the scope of services it provides.

For the purpose of this report, cost of services under PHPs is the amount of the capitation payment tendered to PHP contractors. There are basically four different capitation payments, one for each of the four public

assistance aid categories in the Medi-Cal program: Old Age Security (OAS), Aid to the Blind (AB), Aid to the Totally Disabled (ATD), and Aid to Families with Dependent Children (AFDC).

Weighted average capitation payments for all PHPs for the months of July, September, and December 1973 and March 1974 were compared to the weighted average projected 1973-1974 fee-for-service cost per public assistance eligible for Los Angeles, San Francisco, Orange, Sacramento, San Diego, Ventura, San Bernardino, and Riverside counties for each of the four aid categories covered by the PHP program.

The table below presents this comparative cost data.

Comparison of Weighted Averages of PHP Capitation Payment Rates and Projected 1973-1974 Fee-for-Service Costs Per Public Assistance Eligible for Selected Counties

	AFDC	ATD	OAS	AB
PHP Capitation Payments	22.43	99.22	31.87	59.90
Projected 1973-1974 Fee-for-Service Cost	23.71	111.50	33.21	65.08
Difference (PHP Capitation Payment - Projected Cost)	-1.28	-12.28	-1.34	-5.18
Difference as Percent of Projected Cost	5.40	11.01	4.04	7.96

The figures presented in the above table only reflect cost for medical care services. The costs incurred by the Department in administering the PHP and fee-for-service Medi-Cal programs are not included in the above cost data.

Five terms will be used in a cost analysis of PHP rates:

1. High -- The highest rate paid for a particular aid category;

2. Low -- The lowest rate paid for a particular aid category;

3. Median -- The rate that is numerically in the middle between the low and high rate;

4. Weighted Average -- The quotient of the total amount of money paid to all PHPs for an aid category divided by the total number of enrollees in all PHPs in that aid category; and

5. Composite -- The quotient of the total amount of money paid for all aid categories divided by the total number of enrollees for all aid categories.

The following tables display data on capitation payments made to PHPs, by corporate organization and length of operation.

CAPITATION PAYMENT DATA FOR JULY 1973

	All PHPs	First Year For-Profit	First Year Nonprofit	Second Year For-Profit	Second Year Nonprofit
AFDC					
High	24.09	21.80	22.77	21.71	24.09
Low	18.00	21.45	18.00	21.20	18.65
Median	21.45	21.80	20.02	21.38	21.06
Weighted Average	21.49	21.55	18.85	21.52	21.63
ATD					
High	111.45	98.60	111.45	100.99	105.84
Low	72.07	98.34	87.00	98.35	72.07
Median	98.34	98.60	95.23	98.35	96.41
Weighted Average	94.43	98.39	90.64	99.89	93.88
OAS					
High	36.41	32.80	36.41	32.82	34.75
Low	21.86	32.75	28.00	30.70	21.86
Median	31.36	32.75	31.18	32.16	28.85
Weighted Average	30.59	32.79	29.40	32.17	30.45
AB					
High	71.39	58.25	58.25	57.98	71.39
Low	40.46	57.87	42.46	55.58	40.46
Median	57.87	58.25	56.63	57.03	57.87
Weighted Average	54.86	57.87	45.78	57.35	55.02
COMPOSITE	27.39	26.78	23.45	28.30	27.49

CAPITATION PAYMENT DATA FOR SEPTEMBER 1973

	All PHPs	First Year For-Profit	First Year Nonprofit	Second Year For-Profit	Second Year Nonprofit
AFDC					
High	25.00	21.80	23.34	23.25	25.00
Low	17.47	18.95	17.47	21.29	19.00
Median	21.37	21.45	19.62	21.82	21.45
Weighted Average	22.54	21.46	19.10	22.31	22.98
ATD					
High	111.45	98.60	111.45	108.01	105.84
Low	77.00	84.65	85.76	93.60	77.00
Median	96.80	98.34	90.93	102.53	96.41
Weighted Average	100.51	97.53	90.71	103.85	100.85
OAS					
High	36.41	32.80	36.41	34.81	34.75
Low	21.86	24.75	24.75	30.53	21.86
Median	31.18	32.75	28.42	32.42	30.53
Weighted Average	32.25	32.05	29.02	32.81	32.46
AB					
High	71.39	59.00	67.84	62.23	71.39
Low	42.46	57.31	42.46	56.19	44.94
Median	57.87	58.25	54.32	61.02	58.02
Weighted Average	60.52	58.41	52.73	60.59	61.21
COMPOSITE	28.84	25.80	23.70	29.43	29.41

CAPITATION PAYMENT DATA FOR DECEMBER 1973

	All PHPs	First Year For-Profit	First Year Nonprofit	Second Year For-Profit	Second Year Nonprofit
AFDC					
High	25.93	21.80	23.34	23.25	25.93
Low	14.10	18.95	14.10	21.29	19.00
Median	21.37	21.45	19.00	21.82	22.13
Weighted Average	22.83	21.13	20.20	22.31	22.96
ATD					
High	111.45	98.60	111.45	108.01	107.13
Low	57.97	84.65	57.97	93.60	85.19
Median	95.96	98.34	90.00	102.53	98.76
Weighted Average	102.33	95.72	95.63	103.18	103.33
OAS					
High	36.41	32.80	36.41	34.81	34.75
Low	22.29	24.75	22.29	30.53	24.94
Median	30.53	32.75	28.00	32.40	31.36
Weighted Average	32.19	31.05	29.49	32.80	32.57
AB					
High	69.57	59.00	67.84	62.23	69.57
Low	40.15	57.31	40.15	56.19	46.69
Median	57.87	58.25	53.64	61.02	57.87
Weighted Average	61.97	58.06	55.85	60.27	63.62
COMPOSITE	28.77	25.08	24.96	29.09	29.53

CAPITATION PAYMENT DATA FOR MARCH 1974

	All PHPs	First Year For-Profit	First Year Nonprofit	Second Year For-Profit	Second Year Nonprofit
AFDC					
High	25.93	21.80	23.34	23.25	25.93
Low	14.10	18.95	14.10	21.29	19.00
Median	21.41	20.98	19.00	21.82	22.84
Weighted Average	22.70	21.14	21.13	22.31	23.54
ATD					
High	111.45	98.60	111.45	108.01	107.13
Low	57.97	84.65	57.97	93.60	85.19
Median	95.48	96.67	90.00	102.53	101.23
Weighted Average	102.12	92.70	96.34	103.17	103.68
OAS					
High	36.41	32.80	36.41	34.81	34.75
Low	22.29	24.75	22.29	30.53	24.94
Median	30.66	31.35	28.00	32.40	32.42
Weighted Average	32.23	30.86	29.57	32.83	32.82
AB					
High	69.57	59.00	67.84	62.23	69.57
Low	40.15	56.40	40.15	56.19	46.69
Median	57.87	58.06	53.64	61.02	59.00
Weighted Average	62.50	59.20	57.75	60.21	64.25
COMPOSITE	28.74	26.21	26.12	29.30	29.90

Analysis of cost data from individual PHPs leads to the following conclusion: First-year for-profit PHPs have a higher composite rate than do first-year nonprofit PHPs. This trend reverses during the second year of operation.

One reason for the wide range of rates for nonprofit PHPs is that they are dispersed in more geographic locations throughout the State than are for-profit PHPs. Rates vary by county under the PHP program, and the more counties nonprofit PHPs are in, the greater the possibility for a wide range between high and low rates for the same aid category.

Organizational structure may also have some influence on differences in rates between nonprofit and for-profit PHPs. Small, hospital or clinic-based PHPs have economies in overhead and operating costs that large, open-panel PHPs cannot take advantage of because of their structural organization.

Analysis of the AFDC rates alone, since these are the rates paid for over 85 percent of PHP enrollees, produces these observations:

1. The low and high rates approved by the Department are both from nonprofit PHPs. For-profit PHPs have a more moderate range of rate variation than do nonprofit PHPs.

2. Variation between the median and the weighted average is greater in nonprofit PHPs than in for-profit PHPs. For all plans, the weighted average is generally higher than the median.

3. First-year PHPs, both nonprofit and for-profit, generally have lower lows, highs, medians, and weighted averages than do second-year PHPs.

4. For first-year PHPs, for-profit weighted averages are higher than nonprofit weighted averages. This tendency is completely reversed during the second year of operation.

For the other aid categories, the following observations are applicable:

1. The low and high rates authorized by the Department are for generally nonprofit PHPs, except for ATD and OAS rates for second-year plans.

2. Variation between median and weighted average is predominantly greater in nonprofit PHPs. For first-year PHPs, medians are generally higher than weighted averages in ATD and OAS aid categories.

3. First-year nonprofit plans have greater highs in ATD and OAS aid categories than do second-year nonprofit PHPs. Second-year PHPs, both for-profit and nonprofit, generally have greater lows, medians, and weighted averages than do first-year PHPs.

4. For-profit PHPs have generally higher weighted averages in all aid categories during the first year of operation than do nonprofit PHPs.

The Department, as part of its efforts to further improve the PHP program, is promulgating regulations concerning financial reporting requirements for PHPs. With adequate financial reporting, in-depth cost analysis of the administrative components of PHPs will enable the Department to continually assess the effectiveness of the PHP program.

FUTURE CONSIDERATIONS

The PHP program has undergone rapid development since the first contract became effective in May 1972. There is no longer a need to demonstrate the viability of the PHP concept. Starting from ground zero in May 1972, PHPs now provide medical care to almost a quarter-million Medi-Cal beneficiaries.

The PHP program has already begun to move into a stage of refinement. There will be continued development of new PHP contracts in this stage, but the focus will be on geographic areas not served by, or determined to need the additional services of, PHPs. The real thrust, however, will be to better answer questions regarding the quality, availability, utilization, and cost of PHP provided health care services.

One variable that, after preliminary investigation this year, does not seem to have a significant effect on the delivery of services in the PHP program is the differences in corporate structure -- for-profit versus nonprofit -- among PHP contractors. A more significant variable in assessing PHP performance is the length of time the PHP has been in operation. Whatever variables are used to assess PHP performance, PHP refinement will be a milestone in the provision of health care to the people of California. Not only is it essential to the existence of the present PHP program, but it is also a crucial step in restructuring our health care delivery system for the benefit of all.