City, the scope of the program is still of great significance.

The recent national elections may bring further changes, and we need to know how we can continue to deliver services. In respect to the types of health services covered, New York City Medicaid encompasses services provided by physicians, dentists, pharmacists, optometrists, podiatrists, hospitals, extended-care facilities, home-health services, and even chiropractic services. All aspects of care are covered, namely preventive, diagnostic, treatment, and rehabilitative services.

We shall endeavor in these papers to share our experiences with you. We shall try to be candid and direct. Hopefully, you will learn from our mistakes, avoid our weaknesses, and replicate only the positive features of our program within your own communities.

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II. ADMINISTRATIVE DYNAMICS IN MEGALOPOLITAN HEALTH CARE

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THE philosophy and operation of Medicaid programs are today the subject of scrutiny in state capitals throughout the country. Only recently, states narrowly escaped another crippling amendment to the Title XIX legislation that would have severely cut back federal financing and medical care. In September the Advisory Commission on Intergovernmental Relations of Congress, sometimes called the "third house," issued a sweeping set of recommendations on Medicaid. The commission, in its report, also raised serious questions about the constitution and administration of Medicaid. News arrives almost daily of states trimming back programs, raising taxes, and "evaluating" eligibility levels, in an attempt to constrain the development of Medicaid. All these items underscore the point of this presentation: the status of Medicaid in the United States is far from a stable one, despite the fact that the program desperately needs administrative stability to succeed. Yet, administrators of Medicaid programs must anticipate further buffeting.

Change requires, for its realization, a dynamic and vital organization which can adapt quickly. Health and welfare organizations, still reeling from recent legislative outpourings, will be hard put to carry out these changes. Administrative structures, just beginning to emerge, will need to be further modified, reshuffled, and reoriented to survive.

This paper focuses on the need to confront this reality, and to establish an administrative structure in health organizations that can handle the chameleon-

like legislative situations we now face, and will undoubtedly face in the future. To accomplish this, I will describe how New York City organized its Medicaid operation (both the ideal and the actual), and draw conclusions based upon the lessons we have learned in the past two years. These lessons will serve to point up some vital administrative facts of life for all health professionals involved in medical care.

We, in the New York City Health Department, perceived Medicaid as a methodology to help us break the mold of charity medicine, or poor quality care for poor people. Most appealing to us was the comprehensiveness of New York Medicaid, with emphasis upon its provision for publicly funded preventive care, as well as treatment and rehabilitation. The infusion of new dollars into the medical care arena could be a powerful incentive to upgrade the quality and the accessibility of health services. Dr. Edward O'Rourke was insistent that Medicaid be structured into the Health Department in the same way as the other traditional health services. To underscore his concern, the recent reorganization of the city's health services into a Health Services Administration places Medicaid, by Executive Order, organizationally into the Health Department. This, then, assigns the broad responsibility of guaranteeing the delivery of high quality personal health services to the Health Department, with the Medicaid mechanism currently being the means to carry this out.

Our enthusiasm about Medicaid is not universally shared among health officials in other states. This is unfortunate. The health payoff of Medicaid is equal to or exceeds any other program extant in public health. For any officials to reject it because it fails to fit the traditional mold is short-sighted. Some health professionals have shunned a role in Medicaid programs because it was "welfare," because they preferred to remain aloof from the private sector—from medical care politics, and from such vulgar, controversial, and sticky subjects as payment for services, inadequacy of claims, and the like. In contradistinction, the New York City Health Department has seized upon the Medicaid mechanism to bring about profound changes in the delivery, financing, and quality of health services.

Organizational Problems

Before Medicaid, New York City had a medical-welfare program. A brief review of this program can provide a historical perspective and insight into present organizational problems.

New York City's great tradition of caring for the medically indigent is reflected in its disproportionate number of municipal hospitals (19), representing almost 40 per cent of total beds in the city, as compared to cities in the rest of the country and the world. In addition, the Welfare Department, through the Bureau of Medical Care, ran a medical-welfare program for recipients of public assistance. This program included such services as physician home visits, drugs, appliances, eyeglasses, outpatient and inpatient hospital care, and dental and optical services for adults. As well intentioned as were the professionals employed in this bureau, the care delivered had inbred all the adverse characteristics of a welfare-oriented medical care program. Medical care was a secondary, or derived service, attached as an adjunct to the department's primary mission of providing public assistance to eligible recipients. This point bears emphasis: the Department of Welfare was in the business of providing social and financial assistance to needy people, and medical care was *one* of many such services. We will see a parallel to this in the Medicaid Program.

The old medical-welfare program had the usual stigmata attributed to such pro-

grams by health professionals: generally poor care given by marginal professionals, inadequate ambulatory services, and little emphasis on standards of quality and evaluation of care. The last items meant that the Health Department had relatively little input into this system of care, although the gap was beginning to be bridged by such men as Alonzo Yerby and James Haughton, who held dual appointments in both Health and Welfare.

Prior to Medicaid, this was the melancholy situation that existed. Then, without much advance warning, Medicaid emerged on the horizon and was federally enacted in July, 1965. New York State was one of the early participants, having passed implementing legislation in the form of Title 11 of the New York State Social Welfare Law on April 30, 1966. It was signed the very next day by the governor, amidst statements that a new era of accessible, comprehensive health care was arriving and that now health care was a right to be enjoyed by all, rich and poor alike. The urgency and haste with which New York State passed Medicaid, without really evaluating the administrative machinery and managerial capabilities to handle such a program, is most eloquently explained when one considers that the New York State fiscal year begins, coincidentally, on April 1st, the day New York Medicaid became law. In New York, the Department of Welfare was named the federally mandated "single state agency," and it befell that department to implement the most monumental, meaningful, and momentous program to come out of the 89th Congress. To compound the problem, New York passed a far-reaching, all-inclusive Medicaid package, which included all health services, had the most liberal eligibility benefits of any state in the union (it was estimated before the April 1, 1968, cutbacks that over three million people in New York City could qualify), and mandated local welfare districts to publicize the program in order to encourage all eligible recipients to enroll.

The Welfare Stigma

In New York City, the Medicaid law became heir to the same creaky medical-welfare system described above. Unfortunately, at the time, no structure existed within the Health Department to do standard setting and evaluation. In addition, the Health Department was simultaneously in the throes of thrashing out a reorganization under the mayor's new management program. Since most of the Medicaid recipients were initially on public assistance, the Welfare Department simply extended their old system of paying "vendors" of service, and determining eligibility. Therefore, both pieces of Medicaid were under Welfare jurisdiction: the eligibility and payment functions, and the standard setting and evaluation.

The City Health Department, whose responsibility under state legislation is to set standards for providers of service and to evaluate quality of care rendered, had to rely, in the early stages of the program, upon professionals in the New York City medical-welfare program to perform these functions. As was the case throughout the country, and indeed in New York State, health departments did not have the organizational framework to take on a large medical care program, especially since they were gearing up for a multitude of other new programs, each with its attendant problems. In New York City, an organization to cope with the dimensions of Medicaid did not come into being until April, 1967, a year after the enactment of the law.

By this point in time, the Welfare tail was wagging the Health dog. What was initially hailed as a breakthrough in health legislation, became ensnarled in procedural red tape and stamped with the welfare "stigma." Welfare, whose re-

sponsibility under the law was to determine eligibility and pay providers of service, was tooling up. However, the Welfare Department created no new entity to cope with Medicaid, but merely added to existing staffs and expanded traditional functions. More people were assigned to process the invoices generated from more providers of service. Medicaid, a program with important health goals, quickly became another adjunct to public assistance, home relief, and other forms of welfare. Despite its uniqueness, it was not treated uniquely. Predictably, the public and the professionals thought of Medicaid as welfare, and unfortunately, the welfare image still persists today.

Consequently, health objectives were consistently being blunted by the differences in philosophy between the Department of Health and the newly named Welfare Department, now the Department of Social Services. Because providers of service were not paid promptly, due to lack of adequate administrative machinery, it was difficult to sell Medicaid to physicians. We were and are still greeted at medical society meetings with the question: "Why can't Medicaid be like Medicare and pay on time?" This is paradoxical, since it was the physicians who fought against Medicare and were in favor of Medicaid!

The Health Department did not stand idly by. We moved in aggressively in an attempt to redefine program direction. In fact, on occasion we overstepped traditional administrative bounds, most notably in our efforts, last year, to launch a massive drive throughout the city for enrollment of all eligible individuals in Medicaid.

Our first thrust in program redefinition was to restructure Medicaid along sound managerial lines. We attempted to set up a single unit, outside of both Health and Welfare, to run Medicaid. The bicephalic administration of Medicaid, by Health and Welfare, made no practical sense to us at all. We proposed, as an alternative, that an organization be created by separating out the Medicaid functions from both departments. This organization would then be run along the lines of an insurance company, with a subscriber section to handle enrollment, a claims-processing section to handle payment, and a provider relations section to handle standards and evaluation. A systems and statistical group would serve on a staff level to work on problems across the board. This managerial concept, which incidentally was later recommended by a private consulting group, was rejected by the Welfare Department as being neither politically nor operationally feasible. Welfare contended that Medicaid could not be separated out from other welfare activities. We disagreed. Therein lies a basic conceptual disagreement that will need to be resolved by DHEW and the experience of other states in structuring their Medicaid programs.

Having lost this initial skirmish, we decided to absorb the old Bureau of Medical Care into the Health Department, thereby coordinating all the standard setting and evaluation personnel under Health Department auspices. This was done over a period of about a year. We brought in top-level professionals to assume direct operational responsibility. We amalgamated all the functions and personnel of the bureau, who were scattered in five locations, into one location for ease in supervision and communication. At present, the old bureau, now renamed the Bureau of Health Care Services, is responsible for all standard setting and evaluation activities of the Medicaid Program. It is staffed by 45 Health Department personnel and 291 employees on the payroll of the Department of Social Services. This has been a relatively happy marriage and is working out functionally.

However, the problems we envisioned, when the Social Services Department

added Medicaid to its existing structure, came to pass and are painfully apparent today. Social Services is hard put to cope with the demands of an ever changing Medicaid Program when alternately faced with a welfare system in crisis. If Medicaid were the only, or primary function of the department, I am certain the picture would be different. Social Services Department executives can only expend limited amounts of administrative energies to resolve Medicaid problems when faced almost daily with sit-ins, strikes, and picket lines.

The Health Department, on the other hand, has a full-time commitment to Medicaid. Despite the fact that Social Services spends close to $20 million a year to administer their piece of Medicaid in contrast to the Health Department's budget of less than three-quarters of a million a year, Health has three times as many top-level executives devoting their full-time energies to the program.

One of the most critical areas of conflict is the control of the computer. This little black box has become the *bête noire* of management science. It is alternately blamed or praised, just as if it were alive. Unfortunately, little reference is made to the people who control its destiny.

The Medicaid computer is in the possession of Social Services. Indeed, Social Services justified its need for the third-generation machine based upon the projected impact of Medicaid. Here, again, we have an example of adding on functions to a system and having these functions submerged or subordinated. Medicaid, which justified the computer in the first place, has become low in the priority scheduling on the computer. The computer has not solved Medicaid problems, but has created additional ones. Providers constantly complain about unreadable statements, mistakes in payment, kickouts, and other computer-related situations.

A case in point has been the inability of the Health Department to develop meaningful data on utilization of services. Claims forms were primarily designed to meet fiscal needs rather than health needs. There is information on the claims tapes which would give data on how many patients used how many services, but even this basic data has yet to come *out* of the computer. Despite the fact that programs to get this data were written over a year and a half ago, they have not been run. This is not to impugn the motives of my colleagues in Social Services. The system—the concept of having the computer responsible to their needs rather than ours—is at fault. The computer, like the executives, has a limited amount of time and energy available for Medicaid. Unfortunately other needs, as determined by the Department of Social Services, are more pressing.

Conclusions

This is the state of the internal problems of Medicaid. A number of important administrative lessons can be drawn, since New York's experience is by no means unique in the country.

The principles of management and organization are as appropriate to the field of health care as they are in industry. Two agencies, with differing philosophies, priorities, and modes of operation cannot jointly run a program. Bicephalic management does not work.

Health departments must become involved in medical economics. In the case of Medicaid programs, this may mean paying the providers of service. With payment comes identification, with identification comes control, and with control comes program direction.

Health departments must set up bureaus or offices of medical care administration, specifically to handle such areas as standard setting, evaluation of public programs, and broad medical

care programs. New types of individuals with new types of talent, who may not be on present staffs of health departments, need to be recruited for these jobs. The rapid entry of health departments into medical care programs dictates the need for this.

In conjunction with concern for medical economics, health departments must control the new tool of data processing, both the input and output. In today's management world, management information systems control operations, as much as dollars. The computer, as the focal point for these activities, must be an adjunct to the health department's involvement in Medicaid. A simple syllogism points the way:

> Knowledge is power.
> The computer is knowledge.
> Hence, the computer is power.

Medicaid should be separated out of traditional welfare activities. Medicaid is not welfare. The program will never realize its legislative potential unless it is so conceived. Planning to implement this philosophy should be pursued before any program is structured.

At this point in time, probably the best administrative model for a Medicaid program can be found in the insurance industry. There needs to be enrollment and certification of beneficiaries, providers of service to give care under certain guidelines, and payment made to the providers after certain conditions are met. These three functions, if brought together under single-management direction, would comprise a workable operation.

It is not too late for public health professionals to act. It is clear that Medicaid will be modified by legislation in the near future. We must now translate our experience into programs, and avoid the mistakes of the past. This is vital if we are to fulfill our public and private trust.

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III. *REALPOLITIK* IN THE HEALTH CARE ARENA: STANDARD SETTING OF PROFESSIONAL SERVICES

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WHAT is exhilaratingly revolutionary about Medicaid is neither the program's more generous enrollment of the medically indigent, nor even its delightful smorgasbord of comprehensive health services. No, Medicaid's critical innovation lurks elsewhere—in its exclusive assignment to the Health Department the heady tasks of standard setting, surveillance, and enforcement of quality in every aspect and every locus of publicly funded personal health care. The crucial legal right under Medicaid to suspend errant professionals and institutions from reimbursement gives to Title XIX administrators "fiscal lever-