

HOSPITAL CONTRACTING  
IN CALIFORNIA

by

Lois M. Olinger  
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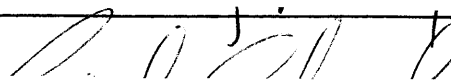
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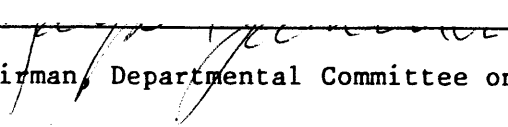
Signature of Author \_\_\_\_\_

Department of Urban Studies and Planning  
May 18, 1984

Certified by \_\_\_\_\_

 Gary Marx  
Thesis Supervisor

Accepted by \_\_\_\_\_

 Ralph Gakenheimer  
Chairman, Departmental Committee on Graduate Studies

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Submitted to the Department of Urban Studies and Planning on  
May 18, 1974 in partial fulfillment of the requirements for  
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ABSTRACT

A case study was conducted on a selective contracting approach to hospital reimbursement for Medicaid recipients in California. The study examines the fiscal and political conditions under which hospital contracting was adopted and the state's organizational response to the program.

Interviews with major actors involved with the hospital contracting process were conducted to gain an understanding of the implementation process and its effect on the state. Respondents included state and legislative staff, spokespersons for the major interest groups, hospital opinion leaders, and other researchers. In addition, a sample of 18 hospitals was selected in which the Chief Executive Officer, Chief Financial Officer, Director of Nursing, and Medical Director were interviewed. A total of 83 interviews were conducted from January 15 to February 8, 1984 in California. Interview protocols were used to structure the interview.

Key findings indicate that the state's 1982-1983 fiscal crisis was the major force leading to the adoption of hospital contracting. However, two additional factors influenced the structural reform: 1) the increasing share that the Medicaid program was consuming of the state's General Funds; and 2) the perverse incentives inherent in the organization of the health care system. The state's organizational response to hospital contracting was based on three problematic conditions: 1) an agency with extraordinary discretionary power was established outside the existing Medicaid agency to negotiate contracts with hospitals; 2) the existing Medicaid agency was responsible for administering the contracts; and 3) the decisions of the negotiating agency was linked to the activities of the administering agency. Implications for the program's success are discussed based on the findings from the adoption process and the state's organizational response.

Thesis Supervisor: Dr. Gary Marx

Title: Professor of Sociology

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## CHAPTER I: OVERVIEW

In the summer of 1982, the California Legislature sought to avoid a major fiscal crisis by adopting a selective contracting approach to hospital reimbursement for Medicaid recipients. This reform is arguably the most drastic change in hospital reimbursement since the inception of Medicaid. This report will examine the conditions under which hospital contracting was adopted and the state's organizational response to this untested, but innovative program.

A cost containment program's effectiveness cannot be assessed solely on the basis of the analytic techniques used to control hospital expenditures. An appreciation of the conditions that surround the adoption process, as well as of the economic and political forces that shape program objectives, must be part of an overall assessment of program outcomes. A historical appreciation is necessary, because those conditions surrounding a program's adoption are ultimately reflected in a program's objectives, authority, organizational structure, and operating characteristics.

This report will provide valuable insight for other states considering similar reform. Similarly, a prior understanding of the setting, actors, and state organizational responses will serve as a foundation for analyzing the effects of hospital contracting on hospitals, patients, and third party payers. Thus, the scope of this report does not include results from the bidding process nor any quantitative analysis, but focuses on an analysis of the early decisions and implementation of hospital contracting.

## 1.1 Historical Structure of Medicaid Program

Medicaid is a jointly funded federal and state entitlement program with eligibility criteria broadly established by the federal government and based primarily on the Aid to Families with Dependent Children and Supplemental Security Income welfare programs. As a vendor payment program, it reimburses individual providers on a modified fee-for-service basis. In particular, hospital reimbursement was required to use Medicare's cost-based "reasonable cost" reimbursement principles.

Historically, Medicaid hospital reimbursement has rested on two broad concepts: cost-based reimbursement and beneficiary freedom of choice. These concepts supported the goal of incorporating the poor into mainstream medicine. The first concept assumed that the most equitable manner of hospital reimbursement for Medicaid recipients was to reimburse a share of the hospital's actual costs proportionate to the Medicaid share of utilization. Medicaid recipients would also be free, according to the second principle, to receive care in whichever hospital they wanted. Thus, Medicaid recipients would enjoy the same access to care enjoyed by any other insured segment of the population.

The Medicaid program, framed by these two fundamental principles, worked remarkably well to increase the access to hospital care for the poor. Unfortunately, as is now universally recognized, these two concepts had other effects. Medicaid hospital payments soared as hospitals discovered they could increase costs with virtual impunity. Other payers were either reimbursing on a cost-related basis or were sufficiently insensitive to cost issues that they failed to counter the cost shift. Medicaid programs had neither a basis for lowering unit costs nor for directing patients to less expensive hospitals.

Throughout the seventies, dissatisfaction with the cost-based approach to hospital reimbursement for both Medicare and Medicaid grew. Demonstration waivers were granted allowing states to control the rate of Medicaid growth with programs which directly regulated the rate of increase in hospital expenses. These programs, through a series of regulatory mechanisms, more or less dictated the amount by which hospital rates could increase from one period to the next. However, these programs continued to require special waivers which were difficult to obtain while the freedom of choice provisions were untouched.

In 1981, Congress adopted the Omnibus Budget Reconciliation Act (OBRA, P.L. 97-35) which encompassed the most radical changes in Medicaid reimbursement since the onset of the program. States were given the flexibility to design alternative reimbursement systems and to obtain waivers from the freedom of choice provisions. With this legislation, the historical principles of cost-based reimbursement and beneficiary freedom of choice became obsolete.

In 1982, California was in the throes of a fiscal crisis and seized the opportunity afforded by the OBRA of 1981. The California Legislature established MediCal (as Medicaid is called in California) reform that was unlike any Medicaid program in the nation. The state was allowed to contract for MediCal services with individual hospitals. Hospitals which did not meet the state's terms, including price, would be excluded from the MediCal program. Reimbursement to hospitals meeting the state's terms would be based on an alternative to the traditional fee-for-service and reasonable cost reimbursement method. Moreover, recipients would be "locked-in" and redirected to those hospitals with MediCal contracts.

Within one year, 246 contracts were signed with hospitals in the areas where the state implemented contracting. Approximately 67 percent of the hospitals and the licensed beds in these areas were under contract, representing about 85 percent of the historical utilization of MediCal recipients (days and admissions).<sup>1</sup> William Guy, the man chosen to direct this program, claimed that hospital contracting was the most significant change in hospital finance since the advent of Social Security.

## 1.2 Methodology

Interviews with the major actors involved with the hospital contracting process were conducted to gain an understanding of the implementation process and its effect on the state. As Table 1.1 demonstrates, respondents included state and legislative staff, spokespersons for the major interest groups, hospital opinion leaders, and other researchers. In addition to these policy level respondents, a sample of 18 hospitals (contracting and non-contracting) was selected in which the Chief Executive Officer, the Chief Financial Officer, the Director of Nursing, and the Medical Director were interviewed. In several hospitals, the Director of Utilization Review and other hospital staff involved with the contract negotiations were also interviewed.

The hospital sampling strategy was based on health care delivery systems, rather than on individual hospitals across the state. Hospitals sharing single market areas were selected. All hospitals within four market areas, or Health Facility Planning Areas (HFPA's) were identified as potential respondents.<sup>2</sup> Four different types of HFPA's were chosen:



Table 1.1: Number of Interviews Conducted by Type of Respondent  
January to March 1984

Hospital Site Visits	18
Hospital Opinion Leaders	9
Medical Lobbies	4
Legislators or Staff	5
CMAC Commissioners	3
CMAC or GOSHN Staff	6
Insurance Companies	4
California Department of Field Offices Health Services (DHS)	5
Other DHS Staff	11
Consumer Advocates	6
Other Researchers	4
County Officials	2
Other <sup>a</sup>	6
<hr/>	
TOTAL	83

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<sup>a</sup>The Other category includes: the Fiscal Intermediary; representatives from the Departments of Finance, Insurance and Corporations; HCFA Regional Office; and the County Hospitals Association.

- an inner city area with high MediCal concentration;
- a non-inner city area with high MediCal concentration;
- a suburban area with relatively low MediCal concentration; and
- a medium sized city.

The California Department of Health Services (DHS) field office was visited and a local consumer advocate was interviewed in each HSPA.

Altogether, 22 hospitals were targeted for site visits. Three declined to participate and one agreed to participate but scheduling difficulties precluded its participation. Table 1.2 summarizes the hospital sample in terms of contracting status, ownership type, bed size and California Health Facilities Commission peer group assignment and compares the sample to all hospitals in the state. It can be seen that the sample of hospitals visited was similar to the state in terms of contracting status and ownership type but was biased toward larger hospitals. This result is not a serious concern since most MediCal services are, in fact, provided in larger hospitals.

The site visits were conducted from January 15 to February 8, 1984 as part of a larger project on hospital reimbursement. Interview protocols were developed and used as a guide to structure the interview. I conducted about two thirds of the interviews, while the site team finished the remaining third. Follow-up telephone calls in February and March supplemented the on-site interviews.

### 1.3 Organization of Report

Chapter II examines the adoption process of hospital contracting. The discussion includes an analysis of the passage of the legislation, a description of the enabling legislation, and an examination

Table 1.2: Characteristics of Sample Hospitals Compared to State  
Hospital Characteristics

	<u>Number In Sample (n=18)</u>	<u>Percent In Sample</u>	<u>Number In State<sup>a</sup> (n=365)</u>	<u>Percent In State</u>
<u>Contract Status</u>				
Contracting	13	72%	245	67%
Noncontracting	5	28%	120	33%
<u>Ownership</u>				
Nonprofit	10	55%	187	51%
Investor	5	28%	123	34%
City, county or district	3	17%	55	15%
<u>Bed Size</u>				
1-99	1	6%	127	35%
100-299	9	50%	161	44%
300 +	8	44%	77	21%
<u>Peer Group<sup>b</sup></u>				
Teaching	3	17%	21	6%
Large complex	8	44%	68	19%
Moderate size	5	28%	92	25%
Small urban	2	11%	107	29%
Other	--	--	77	21%

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<sup>a</sup>Source: Calculated from data for non-exempt hospitals in HFPAs closed by August 1, 1983 as presented in California Department of Health Services, First Annual Report to the Health Care Financing Administration on the Selective Provider Contracting Program, August 1983. There are 104 non-exempt hospitals.

<sup>b</sup>All California hospitals are assigned to peer groups by the California Health Care Facilities Commission.

of the early decisions and implementation of hospital contracting. Chapter III addresses the state's response to the legislation, including questions about the necessity of the organizational requirements of the legislation. Finally, Chapter IV summarizes the key findings of the adoption process and the state's response to hospital contracting. Based on these findings, implications for the program's success are discussed.

## CHAPTER II: ADOPTION PROCESS

Before examining the impetus for legislative change and the roles that various political actors played in how hospital contracting unfolded, it is important to recognize that health care is big business in California. Indeed, as Table 2.1 indicates, there are over 500 hospitals in the state, a third of which are investor-owned. In fiscal year 1981-1982, California hospitals as a whole received close to \$13 billion in revenues, the majority (84%) received for inpatient services. Medicare and private payers were the primary sources, accounting for 82 percent of the revenues, while MediCal accounted for 18 percent.<sup>1</sup>

While total hospital revenues are high, they are distributed among many hospitals within a fragmented and overbedded market. Most hospitals (46 percent) are small containing less than 100 licensed beds and an average occupancy rate of 63 percent.<sup>2</sup> Despite this relatively low occupancy rate, total expenditures for acute hospital inpatient costs in fiscal year 1981-1982 totaled \$8.7 billion, a 19 percent increase over the FY 1980-1981 inpatient costs.<sup>3</sup> The average length of a patient's stay in FY 1981-1982 was seven days, costing close to \$405 day.<sup>4</sup>

These hospital characteristics indicate a fragmented health care market. However, the lobbies representing the health care industry are not. The California Medical Association (CMA) and the California Hospital Association (CHA) are one of the most powerful lobby groups in the state. Neither association had lost a major battle with the California Legislature until hospital contracting appeared.

With these hospital characteristics and political factors in mind, let us now turn to what has been hailed as the most innovative

Table 2.1: Selected Characteristics of the Hospital Industry in California  
Fiscal Year 1981 - 1982<sup>a</sup>

<u>Ownership Status</u>	<u>Percent of Hospitals</u>	<u>Percent of Licensed</u>
<u>Beds</u>	(n = 546)	(n = 89,404)
Non-Profit	45%	55%
Investor-Owned	34%	23%
District/County/City	22%	23%

<u>Bed Size</u>	<u>Percent of Hospitals</u>
	(n = 546)
1 - 99	46%
100 - 299	38%
300 +	16%

<u>Hospital Revenue Source</u> (Gross Revenue = \$12.6 Billion)	<u>Percent of All Services</u>	<u>Percent of Inpatient Services</u>	<u>Percent of Outpatient Services</u>
Medicare	37%	34%	3%
MediCal	18%	15%	3%
Other	45%	36%	10%
Total		84%	16%

Source: California Health Facilities Commission, Report Periods Ending June 30, 1981 - June 29, 1982.

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<sup>a</sup>Includes all hospitals in the state, exempt and non-exempt from hospital contracting.

NOTE: Percents may not sum to 100 due to rounding.

approach to health care cost containment: MediCal hospital contracting. Characteristics of the Medical Program in California are described in Section 2.1 before examining the passage of the enabling legislation in Section 2.2. The Legislation itself is discussed in Section 2.3. Finally, Section 2.4 examines the implementation of hospital contracting.

## 2.1 Overview of MediCal in California

California has one of the more generous Medicaid benefit packages in the United States, providing the services required by federal law as well as offering an extensive list of optional services.<sup>5</sup> The state's eligibility standards for MediCal are similarly liberal including coverage for the Medically Needy and a state-funded program for Medically Indigent Adults (MIAs).<sup>6</sup>

Since its implementation in 1966, the MediCal program has grown into a major enterprise in California, providing over three million recipients with Medicaid benefits. Second only to New York, California MediCal payments to providers exceeded \$4.1 billion in 1981.<sup>7</sup> Incorporating the poor into the "mainstream" health care system appeared, on the surface, to be working. However, by the early 1970's, like the rest of the health care industry, the perverse incentives inherent in cost-based reimbursement was recognized. Structural reforms were advocated, but consensus on what those reforms were to look like was impossible to achieve.

The California Hospital Association (CHA) favored hospital rate regulation as the best approach to insure payer equity. Commercial insurers supported hospital rate regulation as a way of controlling

inflation and cost shifting. Thus, legislation in 1971 established mandatory reporting and disclosure of hospital costs as a preliminary step towards health facilities regulation. While the health care industry was not exactly eager for regulation of any kind, legislative and consumer pressure to control hospital costs was strong.

In 1978, legislators gave the health industry their "last chance" to control hospital costs before government intervention. The CHA and the CMA agreed to a "voluntary effort" at cost-containment in which an annual ceiling of hospital rate increases was identified. However, this voluntary effort failed: in 1981 and the first two quarters of 1982, the California hospitals' rate of increase was above the ceiling.

Anticipating the failure of the voluntary effort, the Legislature enacted AB 251, "MediCal's Six Percent Solution," in June 1981. MediCal inpatient reimbursement in fiscal year 1981-82 was limited to six percent over the average amount paid, on a per discharge basis, during the previous year. In addition, DHS was required to experiment with alternative methods of MediCal management on a limited basis. However, the necessary federal waivers were not granted quickly. The six percent cap was subsequently challenged legally by the CHA. Six months after AB 251 was passed, the court ruled against the state. The DHS was forced to restore interim hospital payment rates to levels in effect prior to January 15, 1982 and was unable to implement its pilot projects. During this same period, the state estimated that MediCal payments would reach \$4.3 billion in FY 1981-82, consuming over 15 percent of the state's General Fund budget.<sup>8</sup>

The continuous escalation in MediCal expenditures was threatening the state's fiscal stability. MediCal had been growing at an



annual rate of 14 percent since the mid-1970's, while the Governor's budget projected General Fund revenue increases of only 9.8 percent in 1982-83. Since 1978, however, the state has had limited capacity to raise revenues. Property taxes, a major source of local revenues, had been reduced by 50 percent when Proposition 13 became effective in June 1978. Under this initiative, property tax increases were also limited to one percent of market value. Additional local revenue restrictions were enacted in November 1979. Proposition 4 limited local and state appropriations increases and prevented local and state governments from retaining surplus funds. In addition to the state's inability to raise local revenues was the general fiscal condition of the country. California was not spared the national economic recessions in 1980 and 1981. In January 1982, projected state revenues were the lowest for any fiscal year in California history. Unemployment, industrial growth, taxable sales and other economic indicators were all below projections.<sup>9</sup>

Compounding California's potential revenue shortfall was the federal government's fiscal crisis. Adopting their own cost-containment measures, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) reduced the federal share of Medicaid reimbursement by three percent in 1982, four percent in 1983, and 4.5 percent in 1984. The estimated impact of these reductions was to decrease California's General Fund revenues by \$76.9 million in 1982-83. Thus, when the California Legislature was faced with the constitutional obligation to balance the state's 1982-83 budget, a \$2 billion deficit was projected.<sup>10</sup> Given the climate of the previous "tax revolts," raising taxes was not an effective option to increase revenues. On the contrary, legislators had to find a way to reduce expenditures.

MediCal, as one observer notes, was a "ripe target" for cutbacks in 1982.<sup>11</sup> The previous legislative session had reduced the state's AFDC program, leaving MediCal and education as the remaining major budget items susceptible to further savings. Proposition 13 had already left its imprint on the educational sector by reducing local revenues. Thus, there was no choice but to target MediCal for "draconian budget cuts".<sup>12</sup> In the spring of 1982, the Legislature, without a clear proposal for reform, agreed to slash \$500 million from the MediCal budget.

## 2.2 Passage of AB 799, AB 3480, and SB 2012

No single approach to the \$500 million budget cut prevailed among the legislators. In March 1982, a small bipartisan working group of legislative leadership began to meet weekly to develop proposals for MediCal reform. The proposals included the traditional options of eliminating or reducing benefits, restricting eligibility, and decreasing reimbursement rates. Hospital rate regulation, favored by many legislators and by consumer, labor and elderly groups, was seriously debated with intense opposition from health care industry lobbyists.

Selective hospital contracting, in a number of configurations, was also discussed. Contracting was not a new concept to the Legislature. In 1972, one form had been implemented within the MediCal program as pre-paid health care. Contracting was further studied by the DHS in 1978, and each year thereafter, contracting was unsuccessfully recommended or introduced into the Legislature. However, in 1982, the factors that previously prevented selective contracting from serious consideration were conspicuously absent. The CHA and CMA had been defeated by their own "voluntary effort," traditional party politics were

united by developing proposals for reform within the working group, and time was running out to balance the state's budget. The state's fiscal crisis, coupled with the unilateral agreement among legislators that MediCal reform was necessary, provoked serious consideration of hospital contracting. Furthermore, barriers to implementation were surmounted when the Federal Omnibus Budget Reconciliation Act of 1981 was passed: HCFA could now grant state waivers for beneficiary freedom of choice and alternatives to cost-based reimbursement.

Selective hospital contracting was gaining bipartisan support by the end of April 1982. However, a DHS working paper reported that selective contracting would take three years to implement--too late to affect the current deficit. Soon thereafter, legislative leaders responded to the DHS conclusion by conceiving of an ingenious approach that would circumvent the bureaucratic delay: a "special negotiator" outside DHS would be created to negotiate selective contracts.

It was at this point that William Guy, retiring president of Southern Blue Cross was invited to speak with the then Governor Brown and legislative leadership. Their discussion focussed on the feasibility of such a contracting program. Mr. Guy, familiar with hospital contracting through his experience with negotiating inpatient reimbursement rates for Blue Cross' HMO, insisted that contracting was possible, but with one crucial caveat: if contracting was to be effective, it had to be implemented quickly by one person with complete authority.<sup>13</sup>

With the apparent endorsement of Mr. Guy, an experienced and respected practitioner, the Legislature promptly drafted legislation incorporating hospital contracting into AB 799, a bill proposing other MediCal amendments. The perception that hospital contracting would

introduce "competition" into the health care system attracted instant legislative support. Indeed, an approach that created incentives to reduce hospital costs and satisfied the health industry's opposition to regulation was appealing.

The CHA and CMA reactions to AB 799, however, were far from supportive. While the CHA publicly endorsed the principle of "competition," the legislature's translation lacked adequate safeguards to insure access and quality of care. Similarly, the CMA, always protecting the fee-for-service model, perceived contracting to be a threat to this model and to their freedom of medical practice. The powerful lobbies of CHA and CMA, backed by their successful record of defeating major reforms in the health care system, vehemently criticized the legislation without providing any alternatives to solve the fiscal crisis. The Legislature, for the first time in years, did not succumb to the lobbies' pressures.

The insurance industry, on the other hand, saw AB 799 as an opportunity to gain control over hospital costs. Traditionally, insurance companies pay "customary and reasonable" charges, as set by hospitals. However, if the insurance industry was granted the same hospital contracting privileges as the state, then insurers could set the rate. Furthermore, insurance industry analysts realized that Medical contracting could increase hospital charges to private patients. This potential increase in cost-shifting inspired a simple solution: replace the "freedom of choice" clause from the Insurance Code with a provision allowing insurers to negotiate with hospitals for "alternative rates." Thus, "competition" would be introduced into the private health care sector as well. AB 3480 was quickly drafted and tied procedurally to AB 799. AB 799 and AB 3480 were signed into law on June 29, 1982, less than two months after Mr. Guy's appearance.

By all accounts, the legislative process that passed AB 799 and AB 3480 was atypical. The speed with which the bills were passed, the dismal conditions of the state budget, the bipartisan support, and the unsuccessful lobby efforts by CHA and CMA contributed to a process like no other. It was as if all the conventional rules were suspended in order to get contracting through the Legislature. Yet, perhaps, the greatest surprise was the influence of Mr. Guy. One Senate staff member remarked: "That is the first time I have ever seen a bill drafted to fit a person." Indeed, this comment reflects the unmistakable impression that Mr. Guy had on the Legislature.

### 2.3 The Legislation

The legislation enabling MediCal hospital contracting is embodied in two statutes: Assembly Bill 799 (AB 799) and a "clean-up" bill, Senate Bill 2012 (SB 2012). In addition to establishing selective contracting with MediCal, these two bills authorize benefit and eligibility reductions. DHS emphasized that these reductions were reluctantly passed by both Democratic and Republican leadership as a result of the "painful economic realities" to balance the California budget. The total fiscal package of reductions and program reform was estimated to save \$372 million in state funds, rather than \$500 million as originally planned.<sup>14</sup> The reductions in benefits and eligibility are summarized first, before discussing the specific legislation establishing hospital contracting.

The most significant benefit change redefined the definition of medical necessity. Language was adopted by the Legislature that narrowed the definition of "medical necessity." Previously, the standard for

furnishing MediCal benefits simply required a "medical necessity." However, AB 799 fundamentally changed the standard to include only services that are "medically necessary to protect life or prevent significant disability."<sup>15</sup> The effect of this change was to deny coverage for services that are not absolutely necessary to protect life or prevent a significant disability. As a result, MediCal patients will have more difficulty obtaining elective services. In particular, coverage for elective surgery and medical procedures, drug products, podiatric and therapy services, vision care and dental services, were all significantly reduced. The state's prior authorization system is the vehicle through which these services will be denied. In addition to the benefit reductions, MediCal reimbursement to providers was reduced. With few exceptions, reimbursement was reduced by ten percent for the following services: physician and hospital outpatient services; hearing aids; acupuncture, portable X-ray, chiropractor and psychology services; and drug dispensing, laboratory and pathology fees.<sup>16</sup>

The most dramatic eligibility change eliminated the MIA eligibility category from the MediCal program and required county governments to assume responsibility for this population. Counties were given the authority to determine what services will be provided and by whom. Approximately 270,000 MIAs statewide were affected by this shift in responsibility. However, counties were funded with only 70 percent of the costs that would have been expended under MediCal for the period of January 1 through July 30, 1983. On an annualized basis, this allocation represented an 85 percent funding level.<sup>17</sup> This shift in MIA responsibility was estimated to produce the greatest savings in general funds.<sup>18</sup>

In addition to eliminating the MIA category from MediCal, other eligibility reductions embodied in the legislation meant that people will have to spend more of their own money on their health care needs each month before they are eligible for MediCal. Specifically, the needs standard for MediCal was reduced to the lowest level that would qualify California for federal financial participation; special income deductions for the aged, blind, and disabled were eliminated; MediCal coverage for the optional Aid to Families with Dependent Children-Unemployed adults (AFDC-U) was eliminated; parental responsibility for children over 18 was increased; verification of MediCal application information was required before eligibility determination; and real estate value limits were reduced. The effect of these reductions makes it more difficult for people to become eligible for MediCal.

Similar to the changes in benefits and eligibility, hospital contracting was intended to generate short-run savings. For FY 1982-83, hospital contracting was estimated to save approximately \$100 million in general funds. However, the potential for long-run savings and efficiency rests on the fundamental change in the delivery of MediCal and in the reimbursement mechanisms. AB 799 sets forth the legislation establishing this reform.

AB 799 authorizes the Governor to appoint a "special negotiator to negotiate rates, terms and conditions for contracts with hospitals for inpatient services to be rendered to MediCal program beneficiaries." The special negotiator has "maximum discretion and flexibility" to arrange the provision of health services, as long as significant savings are achieved. AB 799 does not discourage a bidding process. Indeed, the legislation specifies that if the special negotiator "deems it expedient, call(ing)

for bids, in lieu of negotiations" is acceptable. The negotiator was to serve for one year, from July 1, 1982 to June 30, 1983, at which time a seven member commission, the California Medical Assistance Commission (CMAC) was to assume all duties, and the special negotiator would become the executive director of CMAC. To expedite the negotiator's responsibilities, all rules and regulations were "deemed to be an emergency...(and) not subject to the review or approval of the Office of Administrative Law." To insure the special negotiator's authority, AB 799 was amended whereby activities "which reveal the special negotiator's deliberative processes, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy" were exempted from public disclosure.<sup>19</sup> The special negotiator was afforded extreme liberty to achieve savings.

In addition to considering the total appropriation, the negotiator was to use nine criteria in Section 14.083 of AB 799 to contract for inpatient services:

- " 1) beneficiary access;
- 2) utilization controls;
- 3) ability to render quality services efficiently and economically;
- 4) demonstrated ability to provide or arrange needed specialized services;
- 5) protection against fraud and abuse;
- 6) any other factors which would reduce costs, promote access, or enhance the quality of care;
- 7) the capacity to provide a given tertiary service, such as specialized childrens' services, on a regional basis;
- 8) recognition of the variations in severity of illness and complexity care; and
- 9) existing labor-management collective bargaining agreements."



Inpatient services provided by childrens' and charitable research hospitals are exempt from the negotiator's provisions, as are inpatient services to beneficiaries "who live or reside farther than the community travel time standard from a contract hospital...if the hospital providing services is closer than a contract hospital."<sup>20</sup>

AB 799 also established a seven member commission, CMAC, which was to assume all the negotiator's responsibilities as of July 1, 1983. However, AB 799 also specified that CMAC take office as of January 1, 1983, six months prior to relieving the negotiator of his duties. During this overlapping tenure with the negotiator, CMAC was required to "monitor and review" the activities of the negotiator. CMAC was given one additional role: to negotiate contracts for hospital outpatient services.

As mentioned previously, AB 3480, a companion bill tied procedurally to AB 799, authorized similar hospital privileges for the insurance industry. While not a focus of this study, commercial insurers' new ability to contract with providers nonetheless affects hospitals' incentives to contract for MediCal patients. Indeed, hospitals could become the battleground in which commercial insurers compete with the state to secure hospital contracts.

AB 3480 authorized insurers to offer two types of health insurance arrangements to its subscribers: preferred provider and exclusive provider packages. Effective January 1, 1983 an insurance company could:

"...negotiate and enter in contracts for alternative rates of payment with institutional providers, and offer the benefit of such alternative rates to insureds who select such providers."<sup>21</sup>

Such contracts could also be negotiated with non-institutional, or professional, providers commencing July 1, 1983. While not stated

explicitly in the legislation, the above arrangement represents a Preferred Provider Organization (PPO). If the insured chooses to receive care from the preferred provider, he will benefit from the alternative rate.

On the other hand, insurance companies could restrict traditional consumer freedom. Effective January 1, 1983, insurers could negotiate and enter contracts which:

"limit payments under a policy to services secured by insureds from institutional providers charging alternative rates."<sup>22</sup>

Similarly, such contracts could be negotiated with professionals beginning six months later. Again, the term "exclusive provider organization" (EPO) was not mentioned, but the limited nature of the contract implies an EPO arrangement. Subscribers using non-preferred providers will not be reimbursed. Reimbursement will be made only in the event that the subscriber uses the insurer's designated preferred provider. The final legislative initiative relating to the insurance industry was contained in the clean-up bill, SB 2012. The Insurance Commissioner, who oversees the insurance industry, was mandated to regulate the provision of EPO's to ensure that EPO contracts:

"...include programs for the continuous review of the quality of care, performance of medical personnel, [and] utilization of services and facilities and costs by professionally unrelated third parties."<sup>23</sup>

#### 2.4 Implementation of AB 799

Implementation of AB 799 was carried out with the same speed and fervor that was applied to its passage. The urgency clause in AB 799 obviously helped. Confronting the Governor was the selection of the special negotiator, or "Czar" as the press appropriately dubbed the

position. Indeed, the early decisions made by the "Czar" and his staff would set the tenor for a new era in health care delivery.

The selection of the "special negotiator" was no surprise. William Guy's appointment was announced in early July 1982, within two weeks of AB 799 enactment. Not only were Mr. Guy's qualifications superb, but he was politically acceptable as well. Initially, Mr. Guy was reluctant to accept the position, as his immediate plans included retiring to Maryland. However, when AB 799 passed with the stipulation that the Czar exist for only one year, Mr. Guy accepted the position. Several respondents characterized the decision as Mr. Guy's "swan song" before his retirement.

The special negotiator's first task was to assemble a staff capable of conducting negotiations with some 500 hospitals. There were no job descriptions, yet ten people were hired: two assistants, six negotiators, a data manager, and a student intern. All positions were exempt from civil service and resided in the executive branch of the Governor's Office of Selective Hospital Negotiations (GOSHNN). Guy sought people with health care experience, but expertise in health care finance, law, or MediCal administration was not necessary. Guy simply wanted people who would not be intimidated by a negotiation process. The process and criteria used to hire GOSHNN staff reflects the non-bureaucratic style Guy was known for. As one respondent noted, "Guy worked out of his hip pocket, there is no paper trail."

Despite Mr. Guy's distaste of bureaucratic detail, there was one task he could not avoid. In order for the state to contract for inpatient services, federal waivers had to be submitted and approved by HCFA. In August 1982, DHS and GOSHNN jointly submitted five waivers from California's state plan:

- 1) Freedom of Choice Waiver: This waiver allowed the state to restrict beneficiary choice to hospitals awarded a MediCal contract;
- 2) Single State Agency Waiver: This waiver allowed the state to create GOSH and CMAC as entities separate from the DHS, the single state agency responsible for administering the MediCal program;
- 3) Alternative Payment Waiver: This waiver allowed the state to negotiate alternative rates of payment that do not necessarily meet the "reasonable and adequate rate" requirement;
- 4) Statewideness Waiver: This waiver allowed the state to phase in the implementation of hospital contracting; and
- 5) Utilization Controls Waiver: This waiver allowed the Director of DHS to waive utilization control requirements for hospitals contracting with the state.

With the federal waivers into HCFA, GOSH was ready to develop a strategy to implement hospital contracting. AB 799 left much of the contracting details to the discretion of the special negotiator. Guy and his staff had many policy decisions to make. Among the early decisions that GOSH resolved included the treatment of beneficiary access and quality of care, the method of reimbursement, the contract form, geographic specifications for negotiation, and the framework for the negotiation process.

The provisions of AB 799 specified that the negotiator had the choice of "call(ing) for bids in lieu of negotiat(ing)" contracts with hospitals.<sup>24</sup> Rather than issue a formal RFP, GOSH favored negotiating contracts with individual hospitals. However, as will be described later, the process that emerged was more akin to a hybrid of both approaches.

The first of nine criteria, expressed in Section 14.083 of AB 799, required that GOSH consider beneficiary access in awarding MediCal contracts. Contrary to the widespread assumption that a limited number of hospitals would receive contracts, Guy explicitly stated a "desire to

contract with every hospital possible."<sup>25</sup> Indeed, former GOSHN staff explained that they deliberately erred in the direction of excess bed capacity, not only to insure access to care, but also to have beds they could bargain with for the second year of contracting.

Beneficiary access to care was insured further by the development of a community travel time standard. If any beneficiary resided further than the standard travel time for his or her community from a contract hospital, DHS would authorize care in the closest non-contract hospital. At GOSHN's request, DHS conducted a study to determine the travel patterns of beneficiaries. Historical travel times for inpatient services were calculated for each county and used by GOSHN in evaluating which hospitals to select as contractors. Using the standards and information on the distribution of beneficiaries in an area, GOSHN could evaluate whether the majority of patients resided within a reasonable geographic distance of contract hospitals.

Similarly, GOSHN had to consider a hospital's "ability to render quality services efficiently and economically" in awarding MediCal contracts.<sup>26</sup> However, GOSHN did not see itself as an authority to evaluate quality of care, nor as a legal entity to enforce sanctions against providers not meeting quality standards. The DHS Licensing and Certification Division maintains this responsibility. Thus, hospitals passing Licensing and Certification audits were considered as meeting the 14.083 quality criteria. On the other hand, GOSHN could ensure that these quality services were rendered equally among patients -- private and government payers alike. Contract offers could not include provisions that segregated MediCal patients from other patients through either services, beds, or buildings. GOSHN would only accept contracts that treated MediCal patients like other patients.

The decision to reimburse hospitals on a per diem basis was considered to be the most expedient payment method, given the circumstances. However, staff claim that they never intended the per diem rate to be the unit of reimbursement forever. At the time, the priority was to identify a reimbursement method that was easy for the state to understand and administer, maximized hospital risk, and required relatively few data to establish a given hospital's preferred contract rate. Psychiatric services were allowed to be a separate rate than general acute services (i.e., medical-surgical, obstetric, pediatric services), favoring that the hospital, rather than the state, be at risk. Under the same assumption, the per diem was to be an "all-inclusive" rate including all general acute services, rejecting a per diem that would allow exceptions for high-cost ancillary procedures.

The model contract further maximized hospital risk. The model contract contained provisions specifying that the hospital was to assume responsibility for all services rendered to MediCal patients, regardless of the origin of the service. That is, if a patient presented himself to the contract hospital and later was referred to another hospital for specialized services, the originating hospital would be responsible for billing the state and reimbursing the receiving hospital. However, deviations from the model contract were common and became the norm, rather than the exception.

The model contract, itself, was originally drafted by GOSH. However, as the agency responsible for administering and signing the hospital contracts, DHS was keenly interested in reviewing GOSH's version of the contract. Several DHS staff reported that GOSH was initially reluctant to have such a review. A former GOSH negotiator, on the other

hand, indicated that DHS comments were welcome, but that GOSHN did not always agree with their suggestions. This tension between GOSHN and DHS eventually erupted, delaying hospital contract implementation by one month.

Specification of the geographic areas on which negotiations would be based was critical. Hospitals had to compete against each other in a given community or area in order to create the incentive to lower their bids. Fortunately, state data bases were organized by health facility planning areas (HFPAs), units long used by HSA's to project bed need and review CON requests. Since HFPAs were accessible and familiar units, GOSHN analyzed historical MediCal costs and utilization of hospitals within one HFPA, as well as comparing HFPA average costs and utilization relative to other HFPAs.

The HFPA sequence in which negotiations took place was also crucial. Anecdotes circulating among hospitals about the negotiation process may influence future negotiations in other HFPAs. Acknowledging this potential learning curve among hospitals, Guy wanted to conduct the first phase of negotiations in HFPAs that would display instructive, "dramatic and decisive results."<sup>27</sup> Urban HFPAs with high concentrations of MediCal patients were selected to be the initial HFPAs in which to negotiate. As Table 2.2 shows, HFPAs with high percentages of historical MediCal expenditures entered the GOSHN negotiations in February 1983. Los Angeles, with the highest historical MediCal expenditure percentage, entered the negotiation process two months later, after observing a much publicized negotiation process in San Francisco.

The proposed framework for the negotiation process was fairly simple. A letter of invitation to negotiate a MediCal contract would be

Table 2.2: HFPA Sequence of Negotiations and Historical Share of Non-MIA Expenditures

<u>Effective Date</u>	<u>HFPA Number</u>	<u>General Area</u>	<u>Percent of Historical Non-MIA Expenditures</u>
February 1983	423,425	San Francisco/	6.5
	Daly City		
	311	Sacramento	3.5
	923,933	Long Beach/Lynwood	6.5
	1418,1420,1422	San Diego	4.5
March 1983	415,417,421	East Bay	5.7
	428,429,431	Santa Clara	4.8
April 1983	903,905,907,909	San Fernando Valley	4.0
	911,913,915,917,919	San Gabriel Valley	4.2
	921,925,927,935	Los Angeles	18.6
	937	La Canada	.0
	1412,1414	San Diego North	.7
May 1983	1012,1013,1014,1015	Orange County	4.9
June 1983	511,513,515,516,517	Merced/Modesto	2.1
	607,608	Central Valley	.2
	703	Santa Cruz	.3
	801	San Luis Obispo	.4
	1209	San Bernardino	3.7
	313	Woodland	.2
July 1983	309,505,509,601,605	Central Valley	4.2
	809,811,901	Oxnard/Lancaster	1.8
	405,411	Contra Costa County	1.4
	1105,1109,1111,1207	Riverside/San Bernardino Counties	2.9
	1416	San Diego North	1.8
	413	Richmond	.6
August 1983	213	Susanville	.0
	408	Fairfield	.2
	617	Bakersfield	1.3
	1107	Banning	.1

Source: First Annual Report to the Health Care Financing Administration on the Selective Provider Contracting Program, Volume 1, California Department of Health Services, August 1983.



sent to every hospital. Hospitals returning the acceptance letter to participate would be invited to Sacramento for two meetings. The first meeting would consist of an orientation to MediCal contracting in which Mr. Guy basically laid out the "rules of the game." The second meeting would be held several weeks later in which the hospital representative(s) would present their bid to one of the six negotiators. The negotiator would ultimately present bids from hospitals in one HFWA to Mr. Guy, the data manager, and the two assistants. Each hospital's bid would be compared to GOSHN's data base of historical costs. If a hospital's bid was too high, that hospital would have a chance to submit another bid. Only Mr. Guy would make the final decision of "yea" or "nay." The negotiator would notify each hospital of their decision, while the Governor's office would issue press releases. An HFWA was considered to be "closed" after all the negotiations were finished. Negotiations were anticipated to span one or two months per HFWA.

The negotiation process was rarely as straightforward as the above description implies. Indeed, the San Francisco experience proves this point. As mentioned earlier, San Francisco was one of the initial HFWAs to negotiate with GOSHN and the first HFWA to "close." The experience in San Francisco resounded throughout the state, and other hospitals took notice. The three largest hospitals providing services to MediCal patients were not awarded contracts: St. Mary's, Mt. Zion, and the University of California at San Francisco (UCSF). Together, these three hospitals had historically provided about 40 percent of the MediCal days in San Francisco. As the first HFWA to "close," the exclusion of these three hospitals sent a powerful message to hospitals in other HFWAs: play GOSHN's game, or don't get a MediCal contract. Outraged, St.

Mary's and Mt. Zion hospitals brought lawsuits against the state claiming that the state had made "arbitrary and capricious" decisions. St. Mary's hospital went so far as to obtain a restraining order preventing the state from excluding them from the MediCal programs. To avoid a long and costly court battle, Guy "reopened" the San Francisco HFPA five months later. Every San Francisco hospital received a MediCal contract during this second round of negotiations.

After the San Francisco experience, the negotiations in the remainder of the state went relatively smoothly. The remaining hospitals cautiously negotiated with GOSHN, and no other lawsuits or major complications arose. As of June 30, 1983, GOSHN had negotiated contracts with 246 hospitals in 65 HFPA's, representing 67 percent of the hospitals who entered the negotiations and accounting for 85 percent of historical state MediCal expenditures. GOSHN was unable to negotiate satisfactory agreements with hospitals in nine HFPA's, leaving these areas "open." Areas in which other cost-effective health systems were being tested were exempt from negotiations. By May 1983, GOSHN was able to estimate that \$238.1 million would be saved in the MediCal 1983-84 budget, based on a month-of-service cycle. DHS estimated a lower figure, \$162.3 million, based on month of payment.

CMAC appointments were made in late December of 1982. As specified in the legislation, Governor Brown appointed three commissioners, one of whom was designated as the Chairman. The Speaker of the Assembly and the Senate Rules Committee appointed two commissioners each. The composition of the seven member CMAC resulted in a majority of Democratic appointees. The commission included health care specialists and lawyers, businessmen, a former Assemblyman and Congressman, and a physician.

During the six-month overlap in which CMAC and GOSHN coexisted, CMAC met close to once a month to monitor GOSHN activities. In June, CMAC met more often in preparation to take over selective contracting on July 1, 1983. According to AB 799, the Czar was to become the Executive Director of CMAC. However, Guy had earlier made his intentions known, he was going to retire to Maryland. Indeed, on July 1, 1983, Mr. Guy left the state.

### CHAPTER III: STATE ORGANIZATIONAL RESPONSE

Under normal circumstances, the legislature would have empowered the Department of Health Services (DHS), the single state agency responsible for administering MediCal, with the task of negotiating the selective contracts with hospitals. However, under the fiscal crisis, legislators did not believe in the efficacy and efficiency of the bureaucratic DHS. Instead, they brought in an outsider, endowed him with tremendous discretionary powers and flexibility, and set him hierarchically at the same level as the Director of DHS.

The creation of this special office with virtually no legislative or state accountability poses several questions. For example, was it necessary to create a special office with extraordinary powers to implement hospital contracting? What was the relationship like between the administering agency (DHS) and the negotiating agency (GOSHN)? What adaptations did DHS have to make to accommodate GOSHN? And, finally, what existing structures, if any, supported hospital contracting? This chapter examines each of these questions.

#### 3.1 Necessity of Special Office

The need to create a special office to negotiate contracts was virtually unquestioned by respondents. Contracting with hospitals to provide services to MediCal recipients had never been attempted. The unique nature of contracting required, respondents felt, special attention and staff. However, the need to place the special office outside DHS was disputed by several respondents. Similarly, some observers questioned the necessity to endow the special negotiator with extraordinary protection against legal review and public disclosure.

The concept of the "special negotiator" was a response to the legislature's frustration with typical bureraucratic implementation delays. As described in the previous chapter, the Director of DHS publicly announced that implementation of contracting by the Department would take three years. However, the Legislature needed a "quick fix" in order to balance the 1982-1983 budget. Thus, a "special negotiator" with complete authority, and located outside DHS, was established to direct the negotiations. Was it really necessary to create a "Czar," and place him outside the existing MediCal administrative agency?

The creation of a MediCal "Czar," with primary responsibility to negotiate contracts with hospitals, was unprecedented. However, most respondents believed that the only way to achieve rapid savings through contracting was to give one person total command over the negotiation process. Their rationale was based on the assumption that one individual can make decisions more quickly than a commission of individuals. Furthermore, the lack of any legislative oversight insured rapid implementation.

Coupled with this administrative freedom, certain characteristics were necessary for the Czar's success. First and foremost, the Czar, being in a sensitive and powerful position, would have to be immune from political pressure. Second, he would have to be an executive capable of making decisions with limited information. Third, the respect of the health care industry and the confidence of the legislature would be necessary to provide a sense of security in this time of uncertainty. Finally, a "vision" of the health care system was necessary to guide his actions.

Respondents agreed that Mr. Guy had these four characteristics. That he also had a natural gift of charismatic leadership, as well as hospital contracting experience, was a bonus. While it cannot be determined whether Mr. Guy was indispensable, it can be said with certainty that he contributed to the success of hospital contracting.

The necessity to place Mr. Guy and his staff outside DHS, the existing structure to administer MediCal, is less clear. The general perception is that DHS could not have implemented contracting as quickly as an office outside the normal bureaucracy. Former GOSHN negotiators put it this way: "DHS's attitude is to study something forever and then implement it...if it had been up to DHS, they would still be thinking about how to implement contracting." The former Director of DHS confirmed this view with her declaration that contract implementation by DHS would take three years. Furthermore, had DHS attempted to implement contracting, achieving a consensus among the various department divisions would have been a miracle. The department would have been "at war with itself," according to a former DHS staff member.

Despite the pessimism, a few respondents thought that a special office within DHS could have implemented hospital contracting. While in the minority, these respondents cited one advantage of a special office within DHS: the friction between DHS and GOSHN could have been avoided. However, few could imagine Mr. Guy working for the DHS Director. The image of Mr. Guy, with his political savvy and stature, working for a state bureaucrat, like a DHS Director, was quite unlikely.

Similarly, many observers felt that it did not make sense to separate the MediCal administration and contracting functions indefinitely. The need to implement hospital contracting quickly would

not be as acute in the second year since much of the components of contracting would be established in the first year. In addition, DHS staff expressed a proprietary concern that responsibility for negotiating hospital contracts should rest with the MediCal administering agency. Respondents often recommended that once GOSHN's tenure expired and contracting had been set up, the negotiating functions could have been handed over to a special unit within DHS.

The cloak of secrecy surrounding the negotiation process was also questioned by many respondents. The Czar's exemption from public scrutiny of the rates, terms, or conditions of any contracts, coupled with the protection against disclosure of GOSHN's criteria for decisions created a mystique about the negotiation process. Many hospital administrators made a distinction between the need for secrecy about the negotiated contract rates and the terms of the contract. For example, it was accepted that to stimulate competition the negotiated rates should not be disclosed. On the other hand, to keep the terms and conditions of the contract confidential was not understandable. For one thing, not knowing which hospitals provide certain services caused enormous transfer and referral problems. Similarly, financial responsibility for transfer cases became clouded because hospitals were not allowed to disclose the terms of their contracts relating to service provisions. GOSHN staff acknowledged these difficulties, but maintained that for the first year of contracting, GOSHN needed all the leverage they could get. As one former negotiator claimed, "not having people know [the contract terms] was an advantage."

### 3.2 Relationship Between GOSHN and DHS

The relationship between DHS and GOSHN was flawed from the very beginning, through no fault of either agency. By bringing in someone from the outside to negotiate the contracts, the legislature made a stinging statement: DHS was not capable of conducting the negotiations under the necessary deadline. GOSHN and DHS began their working relationship on this awkward footing.

The relationship between GOSHN and DHS evolved into an amicable working relationship, after some initial stormy periods. The tension stemmed from each agency's different objectives. As the state's administering agency and only signer of the contracts, DHS had a vested interest in ensuring that the negotiated contract terms were capable of being operationalized. GOSHN's goal was to negotiate terms and rates that would achieve target savings. However, negotiators would often face a trade-off between achieving a lower rate and negotiating contract terms that would be difficult, if not impossible, for DHS to implement. Ultimately, experience was the best teacher. As one DHS staff claimed, "Learning was evolutionary. The negotiators stopped making mistakes, and we (DHS) stopped asking for certain provisions." However, the types of problems that DHS encountered are instructive.

DHS was entirely excluded from the direct negotiations with hospitals. Nevertheless, DHS's signature on the contracts committed the state to the specified rates and terms. When GOSHN drafted the model contract, DHS was anxious to review it. Despite DHS's concern, GOSHN was reluctant to have DHS participate in the preparation of the model contract. One DHS staff member remarked that "Guy did not want his negotiators to talk to us [DHS] at all." Eventually, DHS had to review



the contracts in order to sign them. Consequently, during the first wave of contracting, DHS demanded that several items be changed in the model contract before the DHS Director would sign them. The changes included: refining the definition of inpatient services so that a hospital's liability for transportation, outpatient, and emergency services rendered prior to admission was limited: easing the requirement that hospitals take action against medical staff who violate the Medical Staff Bylaws: eliminating payment for "administrative days"; eliminating clauses that restricted the MediCal Operations Division Chief's ability to interpret the contracts; and adding a section mandating that the entire contract be confidential.<sup>1</sup>

Another issue that disturbed DHS was the lack of standardization among the contracts. While the model contract served as a starting point, the number and type of variations in contract terms achieved by the end of the negotiation process was illuminating. As a DHS member said, "The contracts are not the creatures that people think they are." DHS encouraged the negotiators to negotiate consistent language and terms, but did not feel they were successful. There were at least four major departures from the standard contract:

- (1) Most hospitals did not assume responsibility for all inpatient services--responsibility was limited to services normally provided at the given hospital. (This variation became the rule, rather than the exception. Thus, each contract was different.)
- (2) Several hospitals negotiated two per diem rates, one for general acute services and the other for neonatal intensive care.
- (3) Some hospitals negotiated capacity limits based on licensed beds or available services.
- (4) Some hospitals negotiated requirements that beneficiaries could not be admitted by physicians without admitting privileges at a given hospital.

These deviations from the model contract allowed hospitals to control their costs and mitigate their fear of patient "dumping" and becoming a "MediCal hospital."

The most critical issue dividing GOSHN and DHS was over Appendix A of the contract. The intent of Appendix A was to specify the services excluded from the negotiated contract. Initially, this included a narrative summary of the excluded services. However, the ambiguities inherent in the text led DHS to request an explicit list of excluded services. As a result, Appendix A lists the billing codes for excluded services (i.e., not billable by the individual hospital).

Many providers in the first wave signed their contracts before these billing codes had been filled in. The Director of DHS, on the advice of her attorneys, refused to sign any hospital contracts unless these billing codes were complete. GOSHN did not see the need for the delay. The disagreement over Appendix A erupted in front of Governor Brown, himself, right before his departure from office in December. The Governor, anticipating an announcement of contract implementation as one of his last acts in office, threatened to fire the DHS Director if she did not sign the contracts. However, his own counsel advised him that the DHS Director was correct in suggesting a delay in implementation. The dispute between DHS and GOSHN over Appendix A, coupled with the other changes, delayed the contract effective date from January 1, as originally planned, to February 1, 1983 as DHS advocated.

Despite these difficulties and one month delay, GOSHN and DHS completed all the tasks required to implement hospital contracting. DHS cooperated in providing GOSHN with hospital-level data on historical costs

and utilization; an agreement about the model contract was reached; a contract review and monitoring system was established; and the list could go on. Such an accomplishment is noteworthy.

### 3.3 Organizational and Procedural Changes in DHS

As mentioned previously, AB 799 accorded DHS the responsibility of signing each hospital contract, thereby committing the state to the specified rates and terms. However, the DHS Director's signature represented more than the state's agreement with the contract. It also represented a commitment to monitor hospital's compliance with their contracts. Establishing the mechanisms to sign and monitor hospital contracts required a number of organizational and procedural adaptations.

Seven divisions within DHS and the Department of Finance reviewed the proposed hospital contracts for the DHS Director's signature during the first year of negotiations. The DHS divisions included Audits and Investigations, Licensing and Certification, Policy and Procedures, Operations, Fiscal Intermediary Management, Administration, and Legal. Given the pressure to implement hospital contracting as soon as possible, GOSHN allocated five days per contract during which DHS was to solicit comments from all seven divisions and incorporate the changes into the contract. Although this new review function was assigned to these divisions, no new units or staff were added to assist the process.

The Legal Division was the hub of all the activity. The proposed contract was circulated among the divisions for their comments before Legal rewrote the contract. However, it did not take long to figure out that circulating the contracts among the other Divisions was going to exceed the five day limit. The Legal Division hired runners to

run between departments which helped to speed up the process. The proposed contracts, along with each Division's comments, landed on the desks of the four Legal staff who rewrote and modified the contracts. More often than not, the five day review process turned into three hectic days in which comments were solicited and the contract was modified. It was a "wild and wooly period," to use the words of one DHS respondent.

As a result, 246 hospital contracts were negotiated and signed within six months. Once all the contracts were negotiated, overall responsibility for the hospital contract administration and monitoring passed from the MediCal Legal Division to the Operations Division within the DHS. Contract monitoring produced new duties for some divisions within DHS including developing a beneficiary grievance and provider audit system, adjusting the claims processing system, and creating a method to communicate with recipients, hospitals, and physicians. The Hospital Contracts Coordination Unit (HCCU) within the Operations Division was responsible for the grievance and audit system. The Fiscal Intermediary Management Division (FIMD) within DHS handled the oversight functions for changes to the claims processing system. Recipient notification of changes was handled by the Policy and Procedures Division. Similarly, an ongoing notification system with hospitals and physicians was initiated by HCCU.

DHS monitors client grievances and complaints through the Beneficiary Complaint System. A client can call any DHS Division with a complaint about service, providers or payments and the complaint will be logged on an incident report form and forwarded to HCCU. In addition, contract hospitals are required to establish a patient grievance system in which MediCal patients complete the Patient Questionnaire about their

satisfaction with the care they received. These questionnaires were also monitored by HCCU. According to DHS, the volume of grievances is low-- only about 25 complaints had been received by the end of the first year of contracting. Most of the grievances relate more to the patient's perception of personal treatment rather than to the quality of care. For example, patients would relate how rude a physician was or complained about the hospital's housekeeping and food services rather than complaining about the effectiveness of the procedures or treatments. Although a patient grievance system is in place in each hospital, many patients do not respond to the questionnaires. Many hospitals reported response rates less than ten percent. Thus, reliance on beneficiary input makes it difficult to evaluate patients' satisfaction with their medical treatment under the contracting program.

To gain sufficient quality of care indicators, DHS developed an Incident Review System to monitor hospital's compliance with their contracts. Incident reports are routinely completed by units within DHS who handle complaints from beneficiaries and providers. In addition, any individual, including patients, hospital staff, or MediCal field office personnel, can file an incident report. The types of incidents that are reported involve:

- Admission delays or denials;
- Treatment and Transfer concerns relating to emergency room treatment in a contract facility and transferring the patient to another hospital for admission;
- Transfer concerns related to moving a MediCal patient from one facility to another after the patient has been admitted on an inpatient basis;
- Physician Privilege concerns in which a physician is unable to admit MediCal patients to contract hospitals;
- Emergency Service availability and/or delivery;

- Appropriate Service concerns related to emergency transportation from patient pickup to arrival at the hospital;
- Quality of Care concerns relating to incomplete or unsatisfactory delivery of services.

Most incidents can be quickly resolved by the MediCal Field Office, although both resolved and unresolved incidents are reported to HCCU to be logged in for their review. A MediCal Consultant reviews all complaints and makes an initial referral. For example, quality of care concerns are referred to the Licensing and Certification Division.

Similarly, complaints regarding medical benefits are sent to the MediCal Benefits Branch. Incidents are then categorized into three groups:

- 1) Non-incidents in which the facility activity is deemed appropriate and within the limits of the MediCal model contract;
- 2) Negotiated contract incidents in which the reported event is deemed appropriate as a result of increased risk-bearing deviation from the model contract; and
- 3) Contract violations in which the event is "clearly and specifically disallowed under the terms and conditions of the negotiated special hospital contract."<sup>2</sup>

If contract violations are identified, the facility is issued a "warning letter" in which the facility is informed that it faces possible contract sanctions. However, the sanctions are limited. The first of the available sanctions is to cut off the hospital's cash flow. If the facility continues to disregard the contract violation, the DHS has only one choice--to terminate the hospital's MediCal contract.

While the incident reporting system can have severe consequences, only 13 contract violation warning letters have been sent, and not one hospital has been terminated. Close to 500 incidents have been reported as of November, 1983. Sixty-five percent of these incidents concern emergency room treatment and transfer events. However, the

majority of the incidents are classified as non-incidents. DHS has identified two issues that appear to generate the incidents: 1) the contractually allowable transfer of MediCal patients; and 2) the confidentiality of the hospital contracts.<sup>3</sup>

The high percentage of incidents involving transfer issues indicates a problem with the interpretation or operation of transferring patients. DHS points out that the original intention of the contracting program was to have the initial contract hospital be fiscally responsible for patients who need to be transferred to another hospital. However, through the negotiations, hospitals were permitted to reduce their fiscal responsibility and risk by "delegating" the transfer of MediCal patients to other hospitals when their contract permits it. Thus, when transfer cases are reviewed by the local MediCal field office and the reason for the transfer is unclear, incident reports are filed. The contract provisions most often allow the transfer, but appropriate transfers are not readily identifiable due to the confidentiality of the contracts.

Transfer issues are not the only incidents stemming from the confidential nature of the contracts. Excluded services, as specified in Appendix A, also becomes a reported incident when hospitals are unaware of another hospital's service provisions. DHS cites this example:

A contract hospital transfers a patient to another facility. The contract hospital asserts it is not contractually responsible for the continued care of the patient because the required services are excluded from its contract. The receiving hospital (which does not know the contents of the transferring hospital's contract) requests clarification from the local MediCal Field Office to determine what authorizations for treatment should be obtained. The Field Office staff intervenes to interpret the contract and instructs the receiving hospital on how to seek reimbursement, that is, either from DHS because the contract hospital correctly interpreted its contents or the contract hospital maintains ongoing responsibility for the patient's care.<sup>4</sup>

Such confusion about fiscal responsibility often initiates an incident report. DHS takes the position that until the confidentiality constraints on disclosure of covered/excluded services and risk-limiting provisions are amended out of the contracts, confusion and incident reporting will continue.

Adjustments to the claims processing system also suffered from some of the confidentiality constraints. The claims processing system is contracted out to a fiscal agent, Computer Sciences Corporation (CSC). When hospital contracting was implemented, CSC had to adjust the claims system to reflect each hospital's negotiated contract. FIMD monitored CSC's design and implementation of these change orders. Designing and implementing the changes to accommodate differences in each hospital's contract was not trivial.

Changes to the Provider File included flagging contracting hospitals, excluded services, and the corresponding negotiated rates. Edits to the Reference File affected specific hospital information: contracting hospital ID, rates for covered services (Med/Surg, Psychiatric), excluded procedures or physician services (e.g., radiology not covered), and the effective date of the rate or exclusion. If a radiologist submits a claim for an inpatient service, the correct hospital I.D. must be supplied. Then, the claims system will check the Provider File to see if the hospital contracts with the state and if radiology is a covered service. If radiology is excluded, the claim will be denied. If radiology is covered, the Reference File will verify the hospital I.D. and identify the negotiated rate for the individual service. Thus, one physician's claim for services rendered in one hospital will be denied, but paid for in another hospital.



CSC was given only three months to design, develop, and implement the reimbursement changes orders, at the cost of \$250,000. Total operating costs were close to \$964,000. To say the least, CSC and FIMD found themselves in a quagmire of operational problems. Initially, the system required a series of system change orders. GOSHN negotiators would often fail to consult with FIMD staff on the feasibility of translating contract language into system logic. For example, CSC was unable to identify whether particular services were included in the rate. As a result, many claims were temporarily suspended until the ambiguity in service exclusions was clarified in Appendix A.

Not only were there operational problems, but there were also user problems. The most common of which resulted from contracting hospitals having two provider identification numbers. The old provider ID identified services not included in the reimbursement rate while the new provider ID identified the negotiated per diem. Claims were often submitted with the incorrect ID. These claims were also temporarily suspended until new edits and screens were in place to correct the ID's. Over time and with experience, CSC and FIMD refined the system so that it operated more efficiently and smoothly.

The changes in the MediCal program required that recipients be notified. Prior to hospital contract implementation, the Policies and Procedures Division mailed a brief flyer to each MediCal recipient describing the impending changes. Clients were confused and did not understand the effective impact that contracting would have on them. As a result, DHS asked physicians to inform their MediCal patients of which hospitals were participating in the MediCal program. It was felt that the physicians would be more effective in notifying clients of the impending

changes in hospital status. In addition, the need for recipients to be aware of the changes was not as crucial, particularly since the concept of being "locked out" of a hospital within an area called an HFPA would not be meaningful to them.

In addition to communicating with recipients and physicians, hospitals needed clarification and notification of ongoing issues. The Hospital Contracts Coordination Unit (HCCU) within the Operations Division was established to receive calls from hospitals to clarify contract language, settle delegation issues, and so forth. Most of the calls concerned claims payment problems or medical necessity issues. In addition to fielding questions for immediate resolution, DHS conceived of a "Hospital Contract Letter" series to be sent to all contract hospitals, notifying providers of ongoing developments. However, DHS explained that the series has yet to be written, but was expected to begin in March, 1984.

#### 3.4 Prior Authorization System

A critical feature of implementing hospital contracting was the state's prior authorization system. While not an organizational adaptation to contracting, the prior approval process was a fundamental structure supporting hospital contracting. Under a per diem rate, a financial incentive is created for hospitals to increase their revenues by extending a patient's length of stay or decreasing the number of ancillary procedures. Had the prior authorization process not been in place, hospitals who negotiated MediCal rates lower than their marginal or average costs may have been tempted by this potential loophole. However, the prior approval system maintains such a tight control on the number of

procedures and inpatient days that such abuse was unlikely to occur. Thus, DHS already had a system in place that regulated the most sensitive and vulnerable aspects of hospital contracting -- length of stay and ancillary services.

The prior approval system was implemented in 1967 in an effort to reduce unnecessary procedures and to control extended hospital stays. Treatment Authorization Requests (TARS) are submitted by each hospital to their local Field Office before any procedure or service can be delivered to a MediCal patient. Emergency services are reviewed on a post service basis. If medically justified and documented, the emergency procedure is authorized. Requests to transfer a MediCal patient to another hospital for special procedures also have to be submitted. Local MediCal Consultants review each TAR to approve the treatment as well as the number of inpatient days. Unless proper and complete documentation accompanies the TAR, the hospital is denied payment. Claims are not processed by the fiscal intermediary until the local MediCal office approves each TAR.

Hospital contracting, in and of itself, minimally affected the prior authorization process. There were a few initial problems, some of which were resolved and others that persisted. However, some MediCal Field Office staff actually argued that contracting improved their ability to detect "patient dumping" incidents. To understand this improvement, it is first necessary to describe how transfers are handled by the Field Offices under contracting.

Under contracting, transfer requests are approved only if the procedure is one of the excluded services listed in Appendix A of the originating hospital's contract. In a valid transfer case, the receiving hospital is responsible for billing the state. However, a transfer could

become a "delegation" if the service is covered by the originating hospital's contract, but the originating hospital cannot provide the service (either because their beds are full, or because the originating hospital does not provide the service even though it is not listed in Appendix A). In the case of a valid delegation, the originating hospital is responsible for billing the state.

Transfers and delegations that do not meet the conditions of the originating hospital's contract often include those cases that are economically attractive to "dump" onto another hospital. For example, a high risk and complicated MediCal case requiring a high degree of the hospital's resources is more likely to be "dumped" onto another hospital than a case needing less intensive care. Similarly, some MediCal patients may be "re-routed" to another hospital because beds filled with private payers are reimbursed at higher rates than beds filled with MediCal patients. Thus, field office nurses pay close attention to each transfer request to insure that valid transfers and delegations are approved, and that "dumping" does not occur.

Prior to contracting, field office nurses reviewed transfers, but not with the same intensity as under contracting. For each transfer request, the field office examines the Emergency Room and Transportation Logs at both the originating and receiving hospitals, whereas previously, that log review was periodic. As a result, field office staff felt that they were better able to identify cases that are "dumped" onto another hospital.

These intense reviews for transfer requests are necessary under contracting since a hospital's transfer behavior is dictated by their contract. To conduct this review, field office staff need to be familiar

with each hospital's contract, particularly the excluded services in Appendix A. However, the field offices did not have copies of the contracts when contracting went into effect, creating some confusion about how to deal with those early transfer requests. Ultimately, the contracts were delivered to the field offices and review of transfer cases became somewhat routine. The ambiguity in Appendix A, however, presented constant confusion. One field office administrator explained: "It is still difficult to figure out which hospital is responsible for specific services. We still get some cases where we think one hospital is responsible, but then a lawyer will find a phrase (in the contract) and the hospital won't be responsible.

While hospital contracting did not dramatically change the prior authorization process, the change in the definition of medical necessity did. Language adopted by AB 799 redefined "medical necessity" for care under MediCal to only include services necessary "to protect life or prevent significant disability." Thus, TAR criteria for approving particular treatments was seriously narrowed. In effect, the change made it more difficult for MediCal patients to obtain elective services.

To implement the new definition of medical necessity, the DHS developed five lists identifying allowable procedures. MediCal field offices were to use these lists in approving TARS. The first list included procedures that were automatically denied and if challenged, rarely approved. The second list included procedures generally considered to be elective and were only approved if the procedure met the "life and disability" test or the other criteria. The third list covered surgical procedures requiring prior authorization. The fourth list included procedures typically done in inpatient settings but now rendered in an

ambulatory surgical center. Finally, the fifth list covers common office procedures that would be reimbursed at only 80 percent of the usual MediCal allowance.

Criteria for approving the number of patient days was not as clearly spelled out as the lists for allowable procedures. Formally, field office staff use a manual that cites a standard number of inpatient days by type of diagnosis. However, in practice, field office nurses approve the minimum number of inpatient days they "can get away with," without creating an uproar from the hospital. One field office nurse explained: "As soon as we find one person who goes home a day earlier (than the standard), we lower our standard. If I can squeeze another day out of the length of stay, and make it stick, I will convince others that it works and after a while it will become sort of a state standard." Thus, there is considerably less standardization on approvals for length of stay than on treatments.

Provider reaction to the tightening of the prior approval process was mixed. Most hospitals and the California Medical Association (CMA) believe that the state should provide safeguards against unnecessary utilization. However, CMA claims that:

"specific circumstances for individual patients are unique and prior authorization requirements should not be interpreted arbitrarily. When there is doubt as to the medical necessity, this question should be resolved in favor of the patient and his or her attending physician."<sup>5</sup>

Testimony by providers and individual MediCal recipients before the Assembly Committee on Health in October 1983 cite several cases in which TARs were denied because they were not necessary to prevent death or disability, but nonetheless were a medical necessity. For example, one physician presented this case:

A diabetic was seen in the emergency room one Saturday with a fractured jaw that was terribly swollen. He was sent home over the weekend to put ice on his jaw so that he could be admitted on Monday, his diabetes controlled, and his jaw wired on Tuesday. When he came in on Monday, a TAR was not submitted because the physician was under the impression that this was an urgent emergency case that didn't need a TAR. The admission was denied because the TAR was not submitted on Monday; however, Tuesday's care was covered because the review nurse for MediCal was already in the hospital and saw the case and approved the second day of his stay. That's a situation where the TAR process really interferes with the care that everyone would agree would be necessary. There's no question that someone with a fractured jaw with diabetes needs to be in the hospital.<sup>6</sup>

In addition to the ambiguity over the definition of a medical necessity, hospital revenues are affected. In the above example, since a portion of TAR was denied, the patient would have to pay the bill. In many cases, patients do not have the money so the costs are added to the hospital's charity care. Similarly, a CHA study reported that fewer Medical patients were hospitalized. MediCal patient census dropped by an average 16.3 percent in the fourth quarter, compared to a 9.16 percent decline in the third quarter of 1982.<sup>7</sup> This decrease in MediCal inpatient utilization was in large part due to the change in the definition of medical necessity which became effective in September 1982, during the third quarter. Hospital administrators credited a "reluctance to incur medical expenses during uncertain economic times" and that patients are uncertain about the services available to them. "Fearing rejection, some are reluctant to seek medical treatment." Hospitals expressed a concern about their loss in revenue resulting from the change in definition of medical necessity.

## CHAPTER IV: KEY FINDINGS AND IMPLICATIONS FOR SUCCESS

This chapter presents the major findings regarding the adoption of AB 799 and the state's response to hospital contracting in California. Three questions guide this chapter. The first question asks how did the conditions surrounding the adoption process affect the type of program initially adopted? The second question focuses on how the state's organizational response to hospital contracting influenced the initial stages of implementation. Finally, based on the results of these two questions, implications for the program's success are discussed.

### 4.1 Key Findings: The Adoption Process

The major forces leading to the adoption of and patterns in the process of enacting hospital contracting are based on three interrelated factors:

- the state's fiscal crisis;
- the costly MediCal program; and
- the perverse incentives inherent in the organization of the health care system.

The definition of the problem was ambiguous. To help solve the first issue, legislators relied on solving the second one; and to solve the second one, they felt they had to tackle the third issue. The fiscal crisis was the driving force, but the key to the "MediCal solution" lay in the organization of the health care system. Each 'solution' was conditional on the previous 'solution.' Hospital contracting emerged as a structural reform to the perverse incentives in the organization of the health care system.



At the same time, contracting was intended to save \$100 million in General Funds. These savings would reduce MediCal's share of the state budget which, in turn, would alleviate the state's fiscal crisis.

The combination of the above three concerns overrode any opposition to hospital contracting. In particular, three political strategies insured bipartisan support and passage of AB 799. First, the weekly meetings among the Democratic and Republican legislative leadership united what is typically a partisan issue. Second, AB 799, AB 3480, and SB 2012 were analyzed and rewritten by the same six key members of both Houses and parties. Third, an urgency clause was added to AB 799 and SB 2012 and all three bills were tied procedurally to the Budget Act. Voting against either AB 799 or AB 3480 was, indirectly, voting against the Budget Act. These strategies helped the Legislature gain greater flexibility over and control of the policy-making process. Because of this flexibility and control, the Legislature was in a position to resist external pressure.

Indeed, countervailing forces surrounding the adoption of hospital contracting were ineffective. Efforts by the powerful medical lobbies, CHA and CMA, failed miserably. Their failure advanced the adoption of hospital contracting for two reasons: (1) the perceived crisis and the political strategies counteracted any leverage that CMA and CHA was able to wield; and (2) the lobbies did not propose any alternatives or compromises to the fiscal crisis.

The opposing forces failed, not because their arguments were suppressed, but because of their arrogance. The conspicuous absence of alternative proposals, coupled with their persistent opposition, diluted any effect they might have had on the Legislature. This quote from the San Francisco Chronicle characterizes the situation best:

"What really happened was that CMA outsmarted itself. The Legislature had been their mistress, well paid, for a long time, but when they accused it of being a whore, they overdid it. What they said was 'We have sufficient power to stop your budget if you don't take those items out.' But they did not have the votes."<sup>1</sup>

Efforts by the countervailing forces backfired to a point where compromise solutions were not even considered.

Regardless of the forces working for or against adoption, the fact that this health care reform took place in California should not go unnoticed. California has a history for being in the forefront of things to come. Indeed, the California experience will be a litmus test for other states considering drastic restructuring of their health care system. California's cultural/political orientation influenced the program's degree of deviation from the norm and from existing bureaucratic systems. The state's flair for the unusual created a climate in which hospital contracting could thrive. The California Legislature is accustomed to risk-taking and trying new ideas, like hospital contracting.

The conditions surrounding the adoption process will influence the strategy chosen to implement a program's objectives. For example, where adoption is not crisis-oriented, the legislation may call for a more gradual, phased-in approach (i.e., over 3-5 years) to regulation. In contrast, an impending Medicaid crisis will more likely prompt swift and immediate implementation. However, concomitant with swift implementation is the lack of time to prepare a comprehensive system. For instance, this would include establishing a uniform reporting and accounting system, or developing a detailed rate review process. As a result of this lack of preparation, legal and legislative challenges are likely, as evidenced by the legal battle that ensued in San Francisco.

Indeed, in the first month of negotiations and in the first HFPA to 'close,' three hospitals entered into a lawsuit against the state claiming that the state's decision to reject their bids was arbitrary and capricious. One hospital obtained an injunction to prevent the state from excluding the hospital from the MediCal program. The crisis orientation of the Legislature led to immediate implementation of hospital contracting but, as a result, was vulnerable to appeals and legal challenges.

#### 4.2 Key Findings: Organizational Response

The bills identify the negotiating and administering agencies for implementing hospital contracting with general directions for carrying out tasks. However, DHS and GOSHN are semi- or wholly autonomous and have large discretionary power over their activities. The assumption that policy-makers control the organizational, political and technological processes affecting implementation is threatened by the dual responsibility and relative strength of each agency.<sup>2</sup>

DHS was concerned not only with their legally mandated goals, but also with their organizational maintenance and survival.<sup>3</sup> GOSHN threatened DHS's survival and competence. Tension was created by the mere fact that GOSHN existed outside the normal bureaucracy and was given the responsibility for negotiating the contracts--a responsibility seen by DHS as their domain. This tension was exacerbated by DHS having the responsibility to administer and monitor the contracts, making DHS heavily dependent on the decisions made by GOSHN. Three factors were problematic:

- giving GOSHN a responsibility that would typically be under DHS's authority;
- placing GOSHN outside the existing bureaucratic structure; and
- linking GOSHN's decisions to DHS's activities.

These three legislative mandates established a perfect setting for a "turf" battle.

Decisions requiring joint agreement between DHS and GOSHN instigated the 'battle.' Mutual agreement on the contracts was required before any contract became effective. As described previously, DHS would not sign any contracts that GOSHN negotiated until Appendix A was clarified and completed by the contracting hospital. This 'battle' resulted in a one month delay in contract negotiations.

The complexity of joint action can explain the one month delay. According to Pressman and Wildavsky:

"the probability of agreement by every participant on each decision must be exceedingly high for there to be any chance at all that a program will be brought to completion."<sup>4</sup>

Thus, the one month delay in contract negotiations can be attributed to the initial tension established by the legislation and to the complexity of joint agreement.

In one sense, a one month delay is not a long time. However, given the concern for immediate implementation and that Governor Brown wanted to declare hospital contracting as his last act in office, the delay represented a near disaster. DHS was victorious in asserting itself against GOSHN. Thereafter, GOSHN treated DHS seriously, although somewhat reluctantly. As a result, joint decisions were made with less tension.

The scope of authority vested in the Czar represents the Legislature's sense of urgency and desperation to solve the fiscal crisis. The Legislature needed a "fixer" who was willing to deliberately disregard the hierarchy and to intervene wherever a breakdown occurred.<sup>5</sup> Mr. Guy accepted these terms. As discussed above, the consequences of scant regard for DHS delayed contract negotiations. On the other hand, positive results occurred during the negotiation process with individual

hospitals. It was not uncommon for Mr. Guy to intervene in particularly difficult negotiations. Mr. Guy, the hospital's CEO, and the GOSHN staff negotiator would often arrive at a mutually agreeable contract.

Finally, DHS was given the responsibility of administering and monitoring a program that was shaped by an outside agency. In addition, hospital contracting was not the result of a systematic or pre-programmed set of ideas that DHS had only to execute. It was, rather, the result of a process-oriented, heuristic mode of planning.

It is no wonder that the organizational and procedural adaptations by DHS reflected an ad hoc or "trial and error" approach. The exchange between FIMD and the fiscal intermediary best exemplifies this process. Five change orders were needed to finally arrive at a working payment system. Resolution to problems presented by hospitals calling the HCCU within the Operations Division was similarly evolutionary. Perhaps, "implementation as evolution" describes hospital contracting. As Majone and Wildarsky state:

"Unless a policy is narrow and uninteresting (i.e., pre-programmed), the policy will never be able to contain its own consequences. Implementation will always be evolutionary; it will inevitably reformulate as well as carry out policy."<sup>6</sup>

#### 4.3 Implications for Success

Based on the foregoing discussions, what can be said about the potential success of hospital contracting? This report has examined only two areas of hospital contracting: the conditions surrounding the adoption process and the state's organizational response to hospital contracting. The bidding process, both from the state's and hospitals' perspectives, as well as the impact of contracting on patients, hospitals, or state savings have yet to be considered. Indeed, this report on California is only a beginning.

Yet, a reading of the bills and of statements made by legislators, DHS staff, and legislative analysts involved in the policy-making process, indicate some measures of success. The legislative intent of AB 799 was to:

- decrease the rate of MediCal expenditures;
- slow the rate of all health care expenditures (i.e., using state policy to dampen health care inflation);
- promote organized health care delivery systems;
- promote new methods of reimbursement for health care services; and
- maintain access to quality health care for the poor.

These objectives are multiple and may be vague and competing. "To decrease the rate of MediCal expenditures" may be in conflict with "maintaining access to quality health for the poor." Also, exactly how is "access to quality care" or "decrease the rate of MediCal expenditures" defined? Is there a specific number against which access, quality, or expenditures will be measured?

Similarly, depending on the audience, success will be measured differently. The primary interest groups have competing priorities. For most legislators, the level of state savings will be the priority. Hospital administrators will be concerned with the methods of reimbursement. Physicians will be concerned about the viability of their fee-for-service model, but will also focus on maintaining the quality of services (in terms of high technology and specialization). For MediCal recipients, access and freedom of choice will be at stake. Each priority calls for a different set of measures, not necessarily congruent with one another.

Hospital contracting provoked two fundamental shifts in power and influence. First, there is a shift from DHS to the Czar. The Czar was an attempt by legislators to overcome what they perceived as the unresponsiveness of traditional bureaucracy. In this sense, if the main characteristic of government is not "separation of powers" but rather separate institutions sharing powers, this first shift can be seen as a shift from the executive to the legislative branch of government.<sup>7</sup> If the Czar and GOSHN can transform the relationships between government, hospitals, and physicians in one year, it will be interesting to see if this experience will "transfer" to other sectors of public policy. Replicability can be yet another measure of success.

The second major shift is among providers from physicians to administrators. Alford would categorize this shift from "professional monopolists" to "corporate rationalizers."<sup>8</sup> Administrators will no longer depend solely on physicians to bring them patients and money. For large groups of patients, the "choice" of hospital and/or physician will be determined by GOSHN and DHS. Since physicians are the primary generator of services in a hospital, administrators will have to monitor and control physician activities if they do not want costs to be higher than the negotiated contract rate. This shift has been characterized by Mr. Guy when he said that health care is changing "from a social system....to an economic system."<sup>9</sup> Perhaps, economic factors will be more of a determinant of success than the political and social factors.

## Footnotes to Chapter I

1. First Annual Report to the Health Care Financing Administration on the Selective Provider Contracting Program, August 1983.
2. In three of the four HFPA's some modification to the hospital sampling strategy was made. The largest modification was in the inner-city HFPA in which the number of hospitals was too large to interview all hospitals. After discussion with state officials, staff of the California Hospital Association, and the local Medical Foundation, a particular market area within the HFPA was identified. Smaller modifications were made in one HFPA where a hospital was not contacted because of its historically negligible participation in MediCal. Similarly, in another HFPA, it was necessary to include two hospitals from an adjacent HFPA in order to approximate the market area.



## Footnotes to Chapter II

1. California Health Facilities Commission, Individual Hospital Data for California, Fiscal Year 1981-1982, Table 3.
2. Ibid., Table 2
3. Ibid. (Calculation by author.)
4. Ibid., Table 2
5. The only federal options omitted are private duty nursing and personal care services.
6. Medically Needy persons meet all criteria for categorically needy assistance with the exception of income, and who have incurred relatively large medical bills. Payments for the Medically Needy are jointly financed by state and federal funds. Medically Indigent Adults (MIAs), on the other hand, are totally state funded and include persons who have "sufficient" income to meet daily needs, but not medical expenses, and who are ineligible for Medicaid under the adult or AFDC categories. Often, MIAs receive or are eligible for general assistance under a statewide program.
7. L. Johns, R. Derzon, M. Anderson. Selective Contracting for Health Services in California - Interim Report #1, Lewin and Associates, Inc., September 1983, Appendix B, pg. 4.
8. Ibid., Appendix B, pg. 4.
9. L. Aucoin, L. Duhl. The 1982 California Health Care Reform: A Case Study in Policy Analysis, Western Consortium for the Health Professions, Inc., January 1983, pg. 5.
10. Ibid., pg. 6.
11. L. Johns, Selective Contracting, pg. 29.
12. CHA Insight, Vol. 7, No. 16, March 28, 1983.
13. L. Johns, Selective Contracting, pg. 30.
14. 1982 MediCal Changes: Implementation Status of AB 799 Including SB 2012 and Pending Court Actions, DHS, September 20, 1982, pg. 1.
15. AB 799, Section 38 §14133.3
16. 1982 MediCal Changes, pg. 14-16.
17. Assembly Staff Summary of AB 799 - Robinson, pg. 2.

Footnotes to Chapter II (Cont'd)

18. 1982 MediCal Changes, pg. 8.
19. SB 2012, Section 2, §6254
20. Ibid., Section 40, §14087(c).
21. AB 3480, Section 8.
22. Ibid., Section 8.7.
23. SB 2012, Section 10.
24. AB 799, Article 2.6 §14081, 14082
25. W. J. Unger. Health Finance Monitor. "HFM Interview: William Guy - California Charts." December 1982, pp. 60-74.
26. SB 2012, Section 38, §14083
27. L. Johns, Selective Contracting, pg. 42.

Footnotes to Chapter III

1. L. Johns, Selective Contracting, pg. 53.
2. Incident Report System: Status Review, January 18, 1984, pg. 8.
3. Ibid., pg. 13.
4. Ibid., pg. 15.
5. Prior Authorization and Medical Necessity, Testimony Before Assembly Committee on Health, October 4, 1983, CMA Testimony, Appendix 1, pg. 1.
6. Ibid., pg. 20.
7. CHA Insight, Vol. 7, No. 16, March 28, 1983.

#### Footnotes to Chapter IV

1. "Inside State Health Care Revolution," San Francisco Sunday Examiner and Chronicle, July 4, 1982, p. 1.
2. Richard Elmore, "Backward Mapping: Implementation Research and Policy Decisions," Political Science Quarterly, 94:4, Winter 1979-1980, pg. 603.
3. D. Mazmanian and P. Sabatier, Implementation and Public Policy, Chapter 2.
4. J. Pressman, A. Wildavsky, Implementation, Second Edition, Berkely, California, 1979, pp. 87-124.
5. E. Bardach, The Implementation Game, Cambridge, Massachusetts, MIT Press, 1977, pg. 65.
6. M. Giandomenico, A. Wildavsky, "Implementation as Evolution" in J. Pressman, A. Wildavsky, Implementation, Second Edition, Berkely, California, 1979, pp. 177-194.
7. This observation is borrowed from L. Aucoin, L. Duhl, The 1982 California Health Care Reform, but comes from E. Redman, The Dance of Legislation, New York: Simon and Schuster, p. 258.
8. R. Alford, Health Care Politics: Ideological and Interest Group Barriers to Reform, Chicago: The University of Chicago Press, 1975, pg. 192.
9. W. J. Unger. Health Finance Monitor. "HFM Interview: William Guy - California Charts." December 1982, pp. 60-74.