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Prologue: With enactment of the Omnibus Budget Reconciliation Act of 1981, Congress released states from federal strictures that previously had limited the ability of these jurisdictions to innovate in their health programming. Since then, many states have taken the opportunity to experiment with new policy approaches in their Medicaid programs. The overriding goal of both Congress and the states has been to moderate the future growth of Medicaid while striving to spend more efficiently the substantial public investment in this health financing program for the poor. One of the states that struck out in new directions was California, a bellwether jurisdiction that operates a $4 billion Medicaid program. In this essay, Lucy Johns, a respected consultant who has been the chief independent evaluator of the new directions taken by California’s Medicaid (Medi-Cal) program, reports on the early lessons learned from enactment of state legislation that directed Medi-Cal to negotiate—in private—contracts with hospitals for the delivery of inpatient services at fixed prices. The secret negotiations produced contracts with reductions of 1.5 percent or more in what the state had previously paid for Medi-Cal financed inpatient services. Recently, many hospitals which contracted with Medi-Cal have indicated that if rates were the only consideration, they would drop Medi-Cal. But so far, competitive pressures, community service commitments, and reluctance to lose even Medi-Cal’s marginal payment in an era of declining utilization have prevailed. Johns, who holds a Master’s degree in public health from the University of California, Berkeley, has been a self-employed health care consultant for a decade. She codirected with Robert Derzon of the consulting firm of Lewin and Associates a study, funded by The John A. Hartford Foundation, of California’s selective contracting experiment. Of the lessons learned, one of the most striking was the rapidity with which change occurred once the state declared its intent to contract with only a limited number of California’s hospitals. One of the continuing questions about this approach is its impact on patient care. The jury is out on this question, but Johns’ personal view is, “if there are serious problems, they are extremely hard to document.”
The full consequences of policy options in health care are rarely understood in advance. This is particularly true of policies involving changes in methods of paying for services. The nature of payment for services is a central organizing principle for the system. Change it, and myriad effects are inevitable. What these effects will be, however, are not necessarily predictable. The complexity of the health care system compounds the possibilities. As one seasoned analyst long ago observed: “The best mix (for policy prescriptions in health care) would include one part of economic concepts to ten parts of institutional knowledge to twenty parts of social judgment.”

The adoption of selective contracting as state policy in California was no exception. The problem to be addressed by state action was clear, but the probable impact of several alternative responses was not. Ultimately, the option selected by the state's political leaders was familiar to them as a concept but completely untested as state policy. This did not deter the governor and key legislators from giving it their enthusiastic support. It did, however, help to attract national attention to the policy and to stimulate widespread questions concerning its effects.

This article provides a description of the problems confronting state policymakers, their response, and some of the effects observable thus far. It concludes with a discussion of implications aimed at those who would imitate California's approach to health care cost containment and at those who would merely understand it. The article is based on a recently published study of selective contracting in 1983 and 1984.

The Problem For State Policymakers

In 1982, California faced an acute state budget crisis. Tax revenues declined suddenly, as nationwide recession struck the state. Proposition 13, passed by the voters as an initiative in 1978, made tax increases legally difficult and politically suicidal. The state constitution requires a balanced budget. Draconian expenditure cuts were unavoidable.

Democratic and Republican state leadership agreed that the state Medi-cal program (Medi-Cal) was a ripe target. The California Medi-Cal program had been a bipartisan venture from its inception, and administrations of both parties had tried unsuccessfully to control its expenditures over

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the years. Early in 1982, the governor and the leadership of both houses of the legislature agreed that $500 million would have to be cut from the Medi-Cal budget for the ensuing fiscal year (FY 1982-83).

The necessity for action to decrease Medi-Cal expenditures created an opening for numerous parties to urge a comprehensive response to the longstanding problem of hospital cost inflation. Although many legislators in the Democratic party and governor Edmund G. Brown, Jr. (D) had long favored systemwide reform, opposition from the California Hospital cost containment was a familiar and divisive topic of legislative debate which had never gained enough support to move, beyond impassioned rhetoric on all sides. The prospect of wholesale cuts in Medi-Cal benefits and/or eligibles to reach a $500 million reduction, however, galvanized politicians, the Department of Health Services, and lobby groups to propose a variety of systemwide reforms intended to reduce inflationary pressure not only on Medi-Cal but on all payers and, ultimately, on consumers and taxpayers.

The Response

Legislation. The legislation adopted in June 1982 combined some conventional cutbacks in Medi-Cal eligibility and benefits with an innovative change in payment for hospital and physician services. The full scope of these changes is shown in Exhibit 1. Medi-Cal savings on inpatient care for FY 1983-84 from the total package approximate $700 million. Of this total, the change in payment for inpatient care was estimated at $184 million (by month-of-payment), or 26 percent of the total savings. It is this latter component only that is the subject of the rest of this paper.

As of July 1982, the Medi-Cal program was authorized to contract with hospitals for delivery of inpatient services at prices to be stipulated in a contract between the state and the hospital. Outpatient services and physicians' services could be brought under contract as of July 1983. Private insurance firms and Blue Cross could contract with hospitals and physicians as of July 1983, for “alternative” (that is, negotiated) rates. This contracting process, dubbed “selective contracting,” is California's unique contribution to the current policy alternatives available to states intent on bringing inflation in health care expenditures under control.

Rationale and expectations. Selective contracting had bipartisan support from its first appearance as a possible response to the state's fiscal crisis. The concept of contracting was a familiar one in Sacramento. A version of it had been utilized under governor Ronald Reagan (R) in the prepaid health plan (PHP) component of the Medi-Cal program. Contracting with hospitals had been studied thoroughly and was favored by
## Exhibit 1
Components Of Health Care Cost-Containment Legislation, California, 1982

<table>
<thead>
<tr>
<th>Statutes</th>
<th>Cost-containment component</th>
<th>Payer affected</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB 799</td>
<td>Transfer of Medically Indigent Adult (MIA) program to counties</td>
<td>Medi-Cal</td>
<td>11/82-1/83</td>
</tr>
<tr>
<td>AB 3480</td>
<td>Tightening of “spend-down” and other requirements</td>
<td>Medi-Cal</td>
<td>9-11/82</td>
</tr>
<tr>
<td>SB 2012</td>
<td>Benefits: Tightening of approval criteria for inpatient care and several outpatient benefits</td>
<td>Medi-Cal</td>
<td>9/82</td>
</tr>
<tr>
<td></td>
<td>Expansion of outpatient surgery list</td>
<td>Medi-Cal</td>
<td>na</td>
</tr>
<tr>
<td></td>
<td>Reimbursement: Across-the-board cut of 10% for many outpatient services, incl. MD fees</td>
<td>Medi-Cal</td>
<td>8/82</td>
</tr>
<tr>
<td></td>
<td>Program reform: Contracting for primary care case management</td>
<td>Medi-Cal</td>
<td>7/83</td>
</tr>
<tr>
<td></td>
<td>Volume purchasing</td>
<td>Medi-Cal</td>
<td>9/82</td>
</tr>
<tr>
<td></td>
<td>Contracting for inpatient care</td>
<td>Medi-Cal</td>
<td>7/83 Private insurers Blue Cross</td>
</tr>
<tr>
<td></td>
<td>Contracting for physician services</td>
<td>Medi-Cal</td>
<td>7/83 Private insurers Blue Cross</td>
</tr>
</tbody>
</table>


“Blue Cross and Blue Shield are entirely separate entities in California. Blue Shield was not affected by the 1982 legislation.

the Department of Health Services under governor Edmund G. Brown, Jr.’s administration. Thus the appearance of contracting among the cost-containment options proposed in the spring of 1982 was not surprising, and acceptance of the mechanism came early and without dispute. The proponents of selective contracting expressly stated that the goal of the policy was the introduction of competition into a field widely assumed to lack any. Selective contracting would encourage third-party payers to act in their own individual, economic interest by negotiating prices for health services that each payer could afford to pay. The sum of such actions would force hospitals and physicians to adjust their patient care decisions to reflect a flow of revenue that would be prospectively fixed to some degree. Selective contracting was expected to introduce some market discipline and its presumed incentives for efficient behavior into the health
Selective contracting had great appeal in Sacramento because it avoided several pitfalls on other paths to cost containment. First, it required no determination by anyone of an equitable level of hospital payment, a necessity under any policy involving hospital rate regulation. Although rate regulation was favored by the governor and had support in the legislature, it had potent opponents who questioned its philosophical appeal and technical feasibility. Second, selective contracting required no imposition of cost-sharing on consumers: if employers were moving towards increased out-of-pocket expenses as a means to reduce use of services, that could not be attributed to any state mandate. Third, selective contracting could substitute for a rapid increase in Medi-Cal arrangements with health maintenance organizations (HMOs), an alternative that had taken the state years to implement effectively on a limited basis. Thus, selective contracting was perceived to be superior to the major existing cost-containment options for both political and technical reasons.

Selective contracting had positive attractions as well. Its reliance on market forces offered a role for state government which was consistent with the values of many interested parties, including providers: Medi-Cal as a prudent purchaser in the marketplace could not be cleanly opposed. Selective contracting introduced an incentive for cost-cutting on hospitals that appeared unavoidable. Since both Medi-Cal and the major private payers would be able to negotiate prices, hospitals wishing to attract contracts would be prompted to cut costs rather than to shift costs. Hospitals' traditional response to reductions in payments from individual payers—increases in charges to all others—would be blocked. Selective contracting also held out the possibility that market forces would succeed in reducing excess hospital bed capacity. There had always been innumerable obstacles to its removal by direct state action, although long viewed by politicians as a source of unnecessary expense and even unnecessary care. If some capacity were to disappear in response to impersonal market pressures, so much the better. Finally, selective contracting was deemed an appropriate response to provider groups who were perceived to be "stonewalling" in 1982 on cost containment. Disillusion with these groups was strong that spring in Sacramento. The novelty and risks of selective contracting, ordinarily serious political obstacles, became, in this atmosphere, positive virtues.

Implementation. Selective contracting riveted attention as much for its mode of implementation in the Medi-Cal program as for the preference for competition that it expressed. For the first year only, a single individual would be appointed by the governor and permitted to operate in secret and without any customary state review procedures to implement an entirely untested approach to cost containment. The only checks on the special Medi-Cal negotiator, or "Medi-Cal czar," were a set of
legislated criteria “to be considered” in the selection of hospital contractors, the governor's high expectations of this official’s good performance, and his own integrity. This mechanism, although at variance with California’s democratic traditions, served to impart an unusual speed and simplicity to the development of contracting policies and procedures. Further, it produced a program of such vigor that the special negotiator's successor agency, a nine-member, diversely appointed commission (the California Medical Assistance Commission, or CMAC) has continued the original operation virtually unchanged.

Among the more significant program policies and procedures set by the Medi-Cal czar and continued by CMAC are: (1) every short-term, acute, general hospital in a given service area which is accredited by the Joint Commission for the Accreditation of Hospitals (JCAH) and not exempt by statute from contracting, is invited to negotiate a Medi-Cal contract; (2) there is a single “model” state contract, which hospitals can attempt to modify through negotiation to suit their individual circumstances; (3) payment under the contract is almost always on a fixed, per diem basis; and (4) there are one-on-one negotiations between a single state negotiator and hospital representatives.

CMAC added one significant contracting policy to those established by the Medi-Cal czar: there would be “no net increase” allowed in contract rates for Medi-Cal hospitals during “round two” of Medi-Cal contract negotiations, that is, July 1983 to December 1984. This policy did not mean that contract rate increases were unobtainable. It did mean that they were difficult to get and that they would be balanced by rate decreases at some hospitals.

Sixty-eight percent of the state's eligible hospitals had participated in Medi-Cal contract negotiations by the end of 1984. Of those participating, 70 percent had won contracts. Hospitals not yet invited to participate include nonacute hospitals, small, rural, often sole provider hospitals, and hospitals in areas under special Medi-Cal cost-containment regimes. The areas in which contracts now exist account for 92 percent of the state's historical expenditures for inpatient Medi-Cal services.

Although CMAC succeeded the special negotiator (July 1, 1983) contracting for outpatient care could take effect, it has chosen not to pursue this task. Rather, CMAC has vigorously pursued contracting on a capitation basis with HMOs. The 1982 legislation permits this (mandates, in fact, at least two pilot programs), and the commissioners are eager to test their own approach to HMO contracting, a perennial problem for the state. The route has been rocky, however, filled with requirements for federal approvals and negotiations with other state agencies. The first set of contracts in three counties is planned for completion late in 1985.

Implementation of selective contracting by commercial insurance firms and Blue Cross came more slowly. Two barriers took more time,
and capital to overcome than many anticipated would be needed. The first was that insurers had to understand and create for themselves a new role as prudent buyers, exercising their market leverage to seek out both efficient and reliable providers. Unfortunately, techniques for identifying such hospitals and physicians are barely developed, and a data base to monitor resulting experience is expensive to create. The second barrier was that providers were not well organized to respond to contract offers or to themselves offer large networks to eager payers. The creation of networks large enough to appeal to a statewide insurer or to a self-insured, multi-site firm requires substantial effort. Institutions have to find compatible partners; physician staffs and hospitals have to work out agreements; policies on pricing and utilization review have to be created; and antitrust considerations have to be evaluated continually.

By the end of 1984, however, many insurers, Blue Cross, and a miscellany of other preferred provider organization (PPO) organizers were known to have concluded contract negotiations with providers all over the state. About fifty PPOs were known to be operational (available in the marketplace for employers and trust funds to offer to employees) as of December 1984. Of these, 60 percent are sponsored by payers, employers, and brokers, while 40 percent are provider sponsored. Twelve of the state's largest insurance firms are known to have sold contracts to employers, and Taft-Hartley trust funds cover about one million insured. Competition for shares of the new PPO market is expected to become intense in 1985.

The Effects

Caveats. The effects of selective contracting are only partially visible at this time. A definitive evaluation of this policy depends on three important pieces of data not yet available: (1) the relative influence of contemporaneous changes in Medicare (TEFRA limits and DRG-based payment) on behavior changes observable at hospitals in 1983; (2) any measurable, and not otherwise explicable, changes in the health status of Medi-Cal beneficiaries and PPO members/participants, beginning in 1983; and (3) the financial and behavioral effects of PPO contracting when PPOs are widely available.

Of these, the first missing item is the most disconcerting, since it may never be known. (It was not within the scope of this study to measure, nor does it appear as an element in any other study we know of.) The last is particularly important, because the statutes enabled the insurance sector, as well as Medi-Cal, to reduce expenditures for health services. It will be another two to three years before any statewide measurement of these effects is possible. The middle item is the most sensitive and controversial, because it involves valuation of life and functioning, comparison
with a spotty baseline, and attribution of complex changes to a single cause. These methodological problems noted, the effects of selective contracting known at present are summarized below.

**Effects on Medi-Cal expenditures.** Selective contracting for inpatient care is estimated by the state Department of Health Services to have saved $184 million in FY 1983-84 and is projected to save $235 million in FY 1984-85 (both by month-of-payment). Actual and projected expenditures for inpatient care since contracting began are shown in Exhibit 2. Note that projected inpatient expenditures for FY 1984-85 exceed actual expenditures for FY 1983-84 by only 1 percent.

### Exhibit 2
**Actual And Projected Medi-Cal Expenditures For Inpatient Care, California, FY 1982-83 Through FY 1984-85**

<table>
<thead>
<tr>
<th>Actual/projected expenditures</th>
<th>FY 1982-83 (billions)</th>
<th>FY 1983-84 (billions)</th>
<th>FY 1984-85 (billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected expenditures for inpatient care</td>
<td>na(^a)</td>
<td>$2.045(^b)</td>
<td>$1.251</td>
</tr>
<tr>
<td>Projected expenditures: percentage change</td>
<td>na</td>
<td>na</td>
<td>–39%</td>
</tr>
<tr>
<td>Actual expenditures for inpatient care</td>
<td>$1.653(^c)</td>
<td>$1.241</td>
<td>–25%</td>
</tr>
</tbody>
</table>


**Note:** Fiscal year begins July 1.

\(^a\) Prior to the 1982 legislation, Medi-Cal expenditure data for inpatient care only were not available.

\(^b\) Projected expenditures absent any 1982 changes.


**Effects on statewide hospital financial and capacity indicators.** The yearly increases in California hospital inpatient expenses and revenues dropped considerably in 1983 and 1984, as shown in Exhibit 3. As argued in a recent publication, it is plausible that the decline in the inpatient expense increase in 1983 was in part attributable to cost-cutting induced by selective contracting, and that the decline in the inpatient revenue increase was in part a reflection of competitive conditions. There have been no decreases, however, in any statistics relating to excess capacity, with the notable exception of percentage occupancy. As shown in Exhibit 4, the number of acute beds continues to increase, hospital closures continue to be very scarce, and capital expenditures leaped in 1984. At the same time, statewide occupancy fell to an all-time low of 56.6 percent. It may, of course, be too soon for competitive forces to affect hospital investment decisions. Or it may be that contracting stimulates investment. Or it may be that other factors in 1984 (interest rates

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Exhibit 3
Annual Rate Of Increase In Hospital Expenditures And Revenues, California And U.S., 1982 And 1983

<table>
<thead>
<tr>
<th>Hospital expenditures and revenues</th>
<th>1982 California</th>
<th>1982 USA</th>
<th>1983 California</th>
<th>1983 USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total expenditures</td>
<td>12.6%</td>
<td>15.8%</td>
<td>6.6%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Inpatient expenditures</td>
<td>13.2%</td>
<td>15.6%</td>
<td>6.7%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Gross inpatient revenue</td>
<td>18.8%</td>
<td>na</td>
<td>na</td>
<td>na</td>
</tr>
</tbody>
</table>


Exhibit 4
Selected Statistical Indicators For Acute, Short-term Hospitals, California, 1981-1984

<table>
<thead>
<tr>
<th>Indicator</th>
<th>1981 % change</th>
<th>1982 % change</th>
<th>1983 % change</th>
<th>1984 % change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross inpatient expenses</td>
<td>18.5%</td>
<td>12.8%</td>
<td>6.6%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Gross inpatient revenue</td>
<td>20.5%</td>
<td>18.9%</td>
<td>11.6%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Patient days</td>
<td>0.2%</td>
<td>-2.6%</td>
<td>-2.7%</td>
<td>-3.7%</td>
</tr>
<tr>
<td>Discharges</td>
<td>1.1%</td>
<td>-2.1%</td>
<td>-1.4%</td>
<td>-1.1%</td>
</tr>
<tr>
<td>Length-of-stay</td>
<td>-1.5%</td>
<td>0%</td>
<td>-1.4%</td>
<td>-2.9%</td>
</tr>
<tr>
<td>Occupancy^a</td>
<td>0.7%</td>
<td>-1.9%</td>
<td>-3.1%</td>
<td>-4.6%</td>
</tr>
</tbody>
</table>

| Number of beds:                |               |               |               |               |
| Licensed                       | 0.2%          | 0%            | 0.3%          | 0.7%          |
| Staffed                        | 0.7%          | 0.5%          | 0.5%          | 0.4%          |

| Total capital expenditures     | na            | na            | 10.9%         | 23.6%         |
|Licensed hospitals (number)     | 550           | 552           | 552           | 553           |
| Closures (number)              | na            | 5             | 9             | 2^b           |


Note: Excludes Kaiser, state. Shriner and dental hospitals.
^aBased on licensed beds.
^bTentative. Includes one acute hospital (21 beds) and one alcoholism hospital.

and Medicare policy on capital costs) had greater influence than contracting considerations.

Effects on quality and access. Selective contracting could, in theory, result in diminution of quality and access due to reductions in costs and prices induced by a scramble for contracts. Concern about this potential
SELECTIVE CONTRACTING

The tradeoff was voiced before any effects of contracting were known, and it continues to be a source of skepticism about the policy. Although there are several methodological problems complicating detection of effects of contracting on quality and access, some body of data on the subject would be preferable to none at all. Unfortunately, there is very little. Available information includes the following: first, our study, which pursued reports of horror stories in the early months of Medi-Cal contracting at a limited sample of hospitals. A few were clearly not exaggerated. A common factor in most of these, however, was initial confusion about, and resistance to, transfer procedures among hospital personnel at both contract and noncontract hospitals. The study concludes, therefore, that “we would not expect to find such serious patient care problems continuing.” By the time the sample hospitals were visited in 1984, no horror stories were reported. Second, an on-site audit of quality and access by the Department of Health Services was released in late 1984. It found “no major deficiencies” at contract hospitals. The report states that “beneficiary access was not significantly affected by contracting,” that “patient acuity remained stable at contract hospitals,” that “nursing care levels were maintained,” and that “administrative changes which may have resulted in lower quality of care for Medi-Cal patients were not observed.” Third, a 1984 federal assessment by HCFA-Region IX, which included on-site interviews, found that “an acceptable level of recipient access” has been maintained and that the “subjective impression” is that “contracting has had no discernible effect on quality of care.” Nevertheless, the recent death of a Medi-Cal patient in Oakland was blamed by a physician on the Medi-Cal contracting program. More systematic and statistically reliable data, competently analyzed by a disinterested third party, would clearly be desirable. We are not aware of any plans by any organization to produce such information.

Effects on providers. Selective contracting began to affect the attitudes and decisions of hospital managers almost as soon as the legislation was passed. Many hospital managers, including county and teaching hospital staff, support selective contracting as state policy and prefer this approach to regulation. It is understood that payers have become price sensitive, that contracts are the key to protecting a hospital’s patient base, and that there are, generally, more hospitals in a given area than payers need for contracting purposes. It is therefore accepted that hospitals have to adapt to competitive conditions, although this acceptance varies from reluctant to fervent. Competition for contracts, especially from large payers like Medi-Cal, Blue Cross and Blue Shield, has been fierce in urban areas.

At the study’s sample hospitals, a number of changes resulted from the contracting legislation. These include: (1) a strong commitment (sometimes a recommitment) to cost cutting, including layoffs of dozens, and even occasionally hundreds, of staff; very tight control of budgets two
years running; and reconsideration of roles and tasks in the nursing staff; (2) an acknowledgement that cost shifting can no longer serve as the primary response to reduced payments by particular payers; (3) a new sensitivity to hospital prices, a wish to maintain average or low charges compared to peers and neighbors; (4) a recognition that securing of contracts might mean agreement to contract prices well below charges; (5) development of a contracting function within management, in the early days always involving the chief executive officer but now often delegated; (6) adoption of aggressive marketing and diversification strategies, the latter ideally a joint undertaking with the medical staff organized for the purpose; (7) a resurgence of interest in multi-institutional affiliations, a form of relationship now characterizing 61 percent of California hospitals; and (8) a renewed concern for the ethics of patient care, apprehension about inadequate care but also questioning of overtreatment.

Uniform statistics that would register these effects could not be obtained from the sample hospitals. The following are suggestive, however: The initial Medi-Cal contract rates as a percentage of prior year per diem reimbursement were 75-80 percent at three hospitals, 92-98 percent at three hospitals, 105-108 percent at three hospitals, and over 110 percent at two hospitals. The current Medi-Cal contract rate as a percent of charges is 55-60 percent at nine hospitals. The current Medi-Cal contract rates as a percentage of costs range from 64 percent to 8.5 percent at five hospitals. PPO contracts typically number over a dozen. PPO discounts off charges, or contractual per diems reduced from charges, range from 0 percent at one hospital, 10-15 percent at two hospitals, 10-20 at two hospitals, 30-40 percent at two hospitals, to about 40 percent at one hospital. The expense increases budgeted for FY 1984-85 were 0-4 percent for six hospitals and 5-12 percent for nine hospitals.

The sample hospitals confirm the absence of effects thus far on capacity. Direct patient care programs have not been eliminated; nor have teaching programs. No beds have been retired; capital expenditures are not being postponed; closure of the facility is unthinkable.

As of the end of 1984, California physicians had yet to feel any tangible effects of selective contracting. The policy, however, has been received with extreme alarm by the solo and small group, fee-for-service practitioner. Contracting is viewed by these physicians as a threat to the autonomy of the profession and to its traditional control over conditions of medical practice. Disaffection from contracting is virtually universal, both among those who have signed PPO contracts and those who have not. Since almost no PPO patients had been seen in 1984, however, no effects, such as changes in patient volume, quality, and doctor-patient relations, could be reported.

Effects on the health insurance marketplace. The effects of selective contracting by private payers are not yet easy to discern. Basic data, such
as the number of provider contracts or their prices, number of purchaser contracts or their premiums, number of people exposed to or selecting a PPO benefit, are not reportable. Even a standard nomenclature for classifying new PPO products does not exist. It is clear, however, that both contracting with providers to form PPOs and marketing of new PPO options to purchasers (employers and Taft-Hartley trust funds) occurred throughout the state in 1984. This implies that 1985 will be an important year for monitoring effects of PPO contacting.

Scattered data from the study’s sample of insurance firms, other PPO organizers, and employers indicate a few effects so far. First, competition among hospitals for contracts with major private payers is vigorous. Second, physician contracting is more arduous for insurers than hospital contracting, even though contract prices are not much reduced, if they are at all, from usual and customary fees. Philosophical issues and utilization review procedures have been highly contentious. Third, PPOs may save insurers money. Some PPO options are reportedly priced at 10-20 percent below indemnity policies. Blue Cross’ Prudent Buyer Plan is being marketed in 1985 at prices unchanged from 1984. Fourth, some insurers believe that they have gained market share as a result of offering a preferred provider benefit (PPB) and they state that some major accounts have changed insurers to take advantage of a new PPB. And finally, the response of employers to new PPO benefit options is cautious, for many reasons. It may take two to three years before a new PPO actually appears as a benefit option for employees.

Other effects. A final effect of some interest is some decline in the political clout of the CHA and the CMA since the contracting legislation was passed over their strenuous objections. The CMA failed to move a major revision to the statutes out of committee in 1983. Both organizations have strengthened member services that can help their constituencies to cope with contracting, but antitrust factors constrain even this activity. Possibly as a result, the bipartisan consensus that produced the original legislation remains intact in Sacramento. Only one amendment to the statutes has been passed, and this has had little effect on their implementation.

Problems. As selective contracting moves into its third year of implementation, only one problem has emerged that could produce a major revision of the policy. This is the pressure on county hospitals resulting from combined effects of contracting, DRG-based payment by Medicare, and the historical burdens of indigent care and inadequate capitalization. The 1985 legislative session has witnessed a surge of political interest in the current financial problems of the disproportionate (that is, indigent care) provider. The nature of the remedy, if any, is quite unclear as yet. But the perennial dilemmas of county hospital financing have been exacerbated by contracting, which may have to be modified by legislation to
Implications For Policymakers

The policy of selective contracting as implemented in California suggests numerous implications for other policymakers, even at this early stage. First, selective contracting, if applicable to both the Medicaid program and to private insurers, is a policy option that can quickly persuade hospitals to moderate inflationary expenditure and pricing behavior. It means that hospitals will lose patients unless they can compete on price for contracts against both neighbors and peers. If such competition involves payers important to the hospital, hospitals will cut costs in order to be able to offer prices that will attract contracts. Every payer need not act at once. In California, the Medi-Cal program moved much faster than private insurers. But the prospect of imminent movement by multiple payers was sufficient to induce unprecedented reductions in budgets and restraints on charges. It is the conviction that there soon will be few, if any, payers to whom costs can be shifted that drives cost containment under selective contracting.

Second, it would not be easy for hospitals to thwart the intended effects of multipayer selective contracting through legal action. The California statutes plainly imply that not every provider is guaranteed or entitled to receive a contract under either a public or private contracting process. The intent was to establish a competitive process and the rules are simple. If the price (and such other conditions as may be specified) is right, a contract will be secured. If a provider fails to win a contract, it is difficult to argue that a violation of due process or some other legal right has occurred. It simply means that the purchaser decided that price and/or terms were not right. Selective contracting appears to bring a long history of provider entitlement to participation in insurance and government reimbursement programs to an end.

Third, politicians must realize that intervention in the contracting process will undermine its competitive incentives, at least at the outset. Executive branch officials and legislators of both parties will be deluged with pleas to intercede for hospitals on the grounds of past performance, community role, or presumed political clout. In California, the politicians have kept away from both the special negotiator’s office and the CMAC and they have yet to respond to any industry pressure for special dispensation for hard-hit facilities. The result has been swift and consistent imposition of competition on the entire industry.

Fourth, although selective contracting implies a reliance on “impersonal market forces” to achieve its effects, the policy requires competent implementation by payers and intelligent response by providers. The California experience in the first two years demonstrates that the theoretical...
tradeoffs for cost-cutting—reductions in access and quality of care—are not inevitable. But the potential for abuse, inequity, and inept adaptation is great. By altering historical flows of referrals and patients, selective contracting places demands on state and insurance company administrators, hospital staff, physicians, benefits managers, and consumers for learning new routines and for using the system effectively. (Close reading of the reports of behavior of both physicians and hospitals in the recent Medi-Cal patient death demonstrates this.) The imposition of market leverage in health care must be accomplished with some care if the potential for harm is not to overwhelm the undeniable possibilities for rational change.

Fifth, the policy of selective contracting will almost certainly not work unless its implementation includes a strong utilization review component. Increased volume can compensate for reduced prices. The California statutes do not acknowledge this. Both the Medi-Cal czar and private insurers, however, understood the relationship between price and volume. Vigorous utilization review was well established in the Medi-Cal program, and the special negotiator expected this activity to counter any tendency towards increased use that per diem payment might provoke, that is, to increase length-of-stay. Private insurers in 1983 believed utilization review to be more important for cost containment than contracting. A universal element in PPO contracts is provision for rigorous utilization review.

Sixth, a policy of selective contracting can quickly undermine the rationale for much existing state regulation of health care. In California, control of capital investment via certificate-of-need (CON) review has been virtually eliminated, and state collection of uniform statistics has been strongly criticized as an improper revelation of proprietary information. Both these policy problems arise as direct results of the new assumptions about competition engendered by selective contracting. Yet some regulation may still serve the public interest and in fact may facilitate contracting. Thus contracting appears to have little effect on capacity, or on investment decisions. CON may still be necessary to protect all payers, regardless of their individual market leverage, from wasteful duplication of acute care resources. Likewise, a more competitive health care marketplace requires data to function effectively. The state requires data to evaluate the policy intended to create the marketplace; payers require data to choose and evaluate efficient providers; consumers require data to make informed decisions about use of services. When state policy prods payers and users to add financial factors to the complex function that is demand for health care, competition means more scrutiny of providers than ever, not less. There may be argument over what kinds of data everybody needs. There can be no argument that some data, uniformly specified, must be routinely collected. Thus a policy of selective contracting, which can appear
to be inconsistent with customary regulatory policies, may in fact gain from them. Policymakers should address these complex relationships from the beginning.

Seventh, selective contracting, for all its potential impact, may be only a transition step towards cost containment that still protects fee-for-service health care. Many employers, payers, and California officials view it this way. They are eager for the next step, which is much more widespread capitation contracting. Capitation is a way to begin to control physician fees and to align physician and hospital incentives without direct negotiations with individual physicians. It would virtually cap state expenditures without having to set utilization standards or provider revenue limits. If hospital use continues to fall, provider interest in HMO contracts may bloom, since such contracts would ensure some flow of revenue independent of utilization. Thus competitive incentives seem logically to strengthen interest in prepaid health care.

Finally, although the incentives in selective contracting may be salutary for the health care system as a whole, the resulting declines in revenues are bound to hurt some providers more than others. Assuming that no a priori exemptions to the policy are granted at the outset (in California, only specialty children's hospitals were exempted from Medi-Cal contracting and these only for two years), this fact will ultimately produce debate concerning society's responsibility to cushion hospitals especially harmed by competition from its otherwise intended effects. In California, the shock of contracting to the county and University of California teaching hospitals is just now becoming an issue in the legislature. Whether selective contracting is the problem, or whether it has simply magnified the traditional dilemma of inadequate payment for the uninsured, non-Medi-Cal patient (the indigent care problem), remains to be decided. Likewise, it is not clear whether a change of policy regarding selective contracting is the proper remedy. If the problem is the inability to continue shifting the costs of uncompensated care and teaching programs to Medi-Cal and private payers, perhaps these functions, if socially valued, should be funded more directly in some manner.

Any state contemplating selective contracting should consider these implications arising from the California experience and be prepared to confront them either in the enabling statutes or shortly after the policy is implemented.
NOTES

5. Ibid.
7. For details concerning implementation alternatives considered and reasons for their rejection, see Selective Contracting: First Report, Chapter 2.
9. Six California counties have or intend to have special programs for Medi-Cal. Johns et al., Selective Contracting: First Report, 51.
12. Johns et al., Selective Contracting: Final Report, Table 2. The methodology for determining Medi-Cal savings from contracting has been reviewed by a third party and is considered basically sound. Abt Associates, “Selective Contracting in California: The First Year” (Boston, Mass.: December 1984, draft).
15. Foremost of these problems is the complexity of measuring changes in quality and access and of attributing significant findings to contracting per se. The potential for patient dislocation, for example, is unquestionably high; measuring its extent would not be a trivial problem. (See Johns et al., Selective Contracting: First Report, Note 28, p. 63.) Secondly, there is no evidence that when restrictions on access are voluntarily chosen, as in selection of an HMO benefit by the working population, quality of care declines. It cannot be automatically inferred, therefore, that limited access entails poor quality or “two-tier” care. A third problem is that precontracting experience may already show considerable restrictions, and thus contracting may simply overlie a perennial pattern of discrimination. Medi-Cal hospital utilization, for example, was highly concentrated prior to contracting. In 1981, 15 hospitals accounted for 25 percent of Medi-Cal expenditures; 151 hospitals accounted for 75 percent. See M. Vaida, “High Medi-Cal Hospitals,” Insight 5 (Sacramento Calif.: California Hospital Association, 19 May 1982): 2. These statistics imply that many providers may have been saying “no” to poor patients even though free choice was an express goal of Title XIX. Finally, there is the problem of the credibility of the investigator of quality or access effects. Technical competence aside, findings may be rejected because “hidden agendas” are suspected.
16. For details concerning the sample, see Johns et al., Selective Contracting: First Report, Chapter 4.
17. Ibid., 84.
18. Ibid., 84.
24. “Death Blamed on Medi-Cal,” The Oakland Tribune, 23 April 1985, 1. A state investigation of this incident concluded that the Medi-Cal contracting program was not the problem. No comparable incidents have been reported before or since.
25. For an analysis of available capacity vs. number of hospitals and physicians under contract, see Johns et al., Selective Contracting: Final Report, Chapter 4.
26. For additional detail and all statistics in this section, see Johns et al., Selective Contracting: First Report, Chapter 3 and Johns et al., Selective Contracting: Final Report, Chapter 3.
27. Selective contracting by private, third-party payers with physicians has promoted the formation of hospital-based, physician organizations separate from the hospital medical staff. These groups, which generally comprise a large majority of the active staff, are termed “parallel medical staff organizations,” or PMSOs, by the California Medical Association. For a survey of hospital CEO views on the potential of these structures, see C. White and S. Lewis, “Changing Hospital/Physician Relationships,” Insight 9 (Sacramento, Calif.: California Hospital Association, 30 January 1985). Also, T. Fourkas, “Independent Hospitals Now An Exception,” Insight 9 (Sacramento: California Hospital Association, 2 April 1985).
29. For additional detail and a classification scheme, see Johns et al., Selective Contracting: First Report, Chapter 5.
33. Note that per case payment, which is compatible with selective contracting although rare as yet, also requires UR to monitor admissions.
35. For details concerning the uneven distribution of contractual allowances by payer and hospital ownership, see C. Arstein-Kerslake, “What Hospitals Don't Get Paid,” Insight 9 (Sacramento: California Hospital Association, 10 April 1985).