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Physician Organizations Assuming Risk: Market and Policy Implications

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A roundtable discussion with

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Physician Organizations Assuming Risk

With health maintenance organizations (HMOs) covering about 30 percent of all Americans and more than 40 percent of the populace in states such as California, federal and state policymakers as well as health plan purchasers have a growing interest in HMO performance.¹ Recent reports of a projected resurgence in medical inflation, HMO pull-outs from Medicare in certain locales, and HMO financial losses industrywide in 1997 are raising concern.² In California and elsewhere, physician organizations are actually bearing much of the financial risk for the HMO plans. How well these physician organizations manage enrollee care and costs—and how well their HMO contracts cover their expenses—will strongly influence HMO industry performance in the coming months and years.

The financial stakes can be high in HMO-provider contracting. Negotiated rates affect the profitability of contracted physician organizations, the amount of income they can distribute to their physicians, and potentially even their solvency. The rates also affect the competitiveness of the HMOs, dictating whether they can offer plan premiums that will be attractive to purchasers. And when providers terminate or are dropped from HMO networks, the result can be disruptive for enrollees, requiring them to pick new plans or new physicians.

Capitation contracting also involves HMOs delegating many managed care functions to providers. For example, capitated physician organizations usually authorize services, subcontract with outside specialists and ancillary professionals to cover the full range of professional services, pay claims, and collect claims data. The physician organizations generally use their own standards of care and treatment guidelines, approved by the various HMOs but not dictated by them, to assure consistency and appropriateness in patient treatment. HMO delegation of these responsibilities to providers has important implications for federal and state policies addressing patient protections, determination of medical necessity of services, quality assurance, data management, HMO performance monitoring, disclosure of physician payment arrangements, and quality improvement.

Assumption of financial risk by physician groups is also contributing to the ongoing re-structuring of health care delivery systems in California and elsewhere. Capitated physician organizations have strong incentives to grow—to spread their risk across larger patient bases,

enhance their management capabilities, and increase their leverage in contracting with managed care companies.³ Small physician groups that are struggling financially have compelling reasons to affiliate with better-capitalized organizations. Examples abound of mergers and growth among medical groups and independent practice associations (IPAs), expansion of physician-hospital organizations, and physicians selling their practices to physician practice management companies (PPMCs). System consolidation is likely to continue because the financial pressures on provider groups and HMOs and the competitive pressures in their markets are so great. Larger, more integrated physician organizations have the potential to improve patient care and to lower costs, but that outcome is not assured.

This Forum session will address HMO capitation contracting, market dynamics affecting physician organizations in California, and policy implications of both.

CAPITATION CONTRACTING MODELS

Under capitation contracting, the provider accepts a payment amount per member per month (PMPM) for each assigned member in exchange for providing (or arranging for) members to receive a prescribed set of services as needed. The financial risk assumed by the provider is whether or not the funds generated by PMPM payments will be sufficient to cover service

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expenses incurred. The PMPM payments are usually either fixed dollar amounts adjusted for the age-sex mix of the assigned members or a percentage of the average net premium the HMO receives from the purchasers for assigned members.⁴

There are three prevalent models of capitation contracting in California. In one model, a physician organization receives capitation payments only for all services of health care professionals; the HMO and contracted physician organization usually have *shared risk* for institutional services (such as those delivered by a hospital, a nursing home, outpatient surgical facilities, or home health). The HMO pays the PMPM amount for professional services to the physician organization directly and sets aside the agreed-upon PMPM amount for institutional services in a risk pool. The HMO pays hospitals and other facilities for the services they provide and divides any money left in the pool with the physician organization. If there is a shortfall in pool funds, the physician organization and HMO share that liability as well. This model is illustrated in Figure 1 (see page 4).

In the *dual risk* model, the physician organization and a cooperating hospital organization (such as a hospital, hospital corporation, or integrated health care system) divide the capitation amount for all medical services for assigned members through two capitation contracts with the HMO. The physician organization takes the risk for all professional services for the assigned members; the hospital organization takes the corresponding institutional services risk in its contract. In this instance, the hospital organization, not the HMO, subcontracts with other facilities as needed for any institutional services that the hospital organization does not provide. Also, the HMO typically does not share in savings from an institutional risk pool. Usually, the physician and hospital organizations have a separate agreement between them to share the risk for institutional services.

The third model is called *global risk* contracting, which entails a health care provider organization taking full risk for all professional and institutional services. Only an organization with a special state license (known as a limited Knox-Keene license) is permitted to assume global risk for both professional and institutional services in California.⁵

Pharmacy services represent an additional category of risk often shared between the HMOs and physician organizations. A pharmacy risk pool may be administered much like the pool for institutional services and, in fact, the two pools may be combined in reconciling amounts

paid and due. As inflationary pressures have mounted, pharmacy risk distribution has grown in importance. Depending on the pharmacy benefit design, patient mix, and coverage of expensive new drugs, pharmacy costs are running anywhere from 12 percent to over 20 percent of average adjusted net premium. These costs are a contentious topic between some HMOs and provider organizations, in part because of a lack of clear understanding between them as to how the HMOs account for drug price rebates and lump sum payments that HMOs may receive from pharmaceutical companies when the HMOs include certain drugs in their formularies.

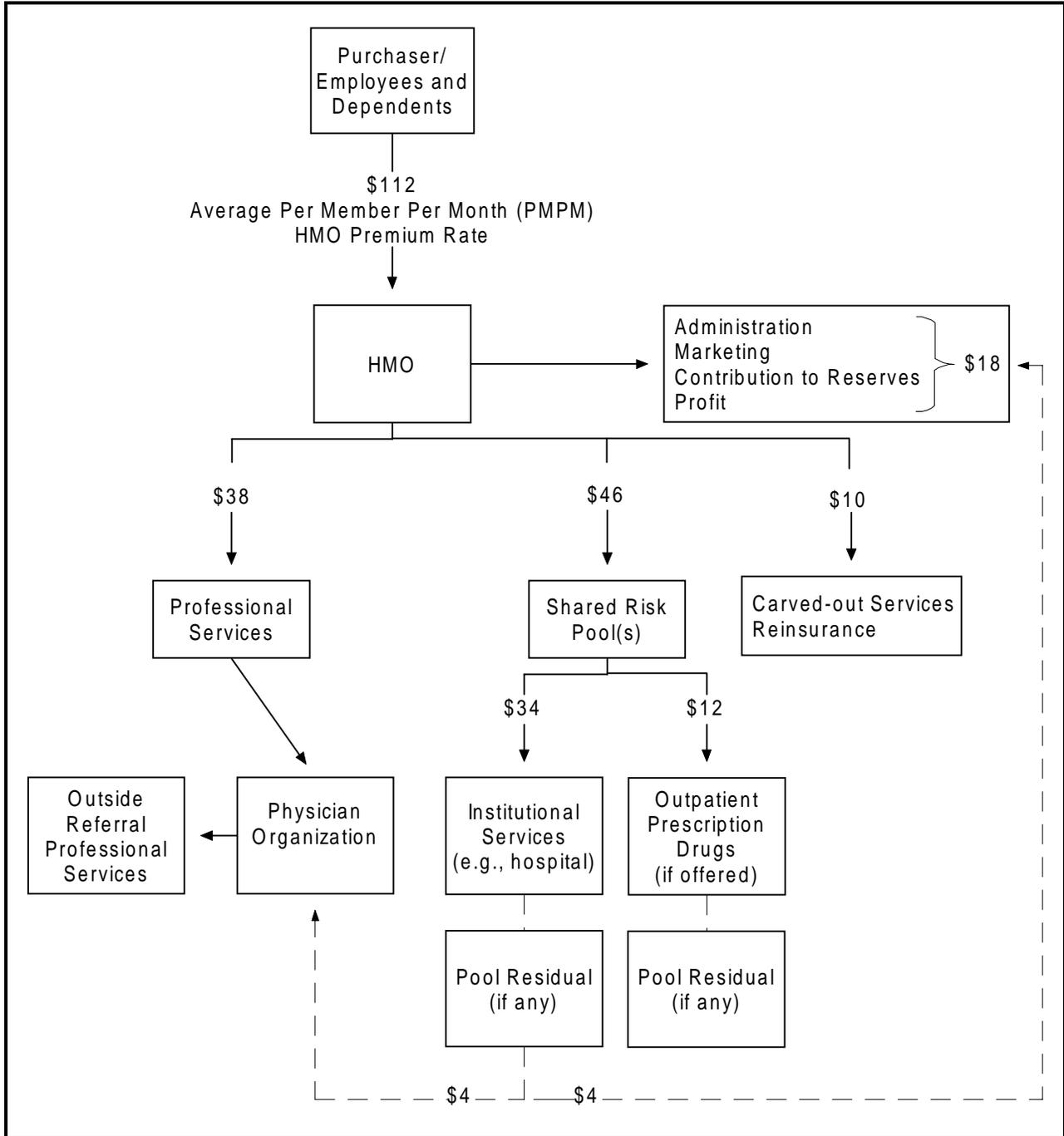
Within these contracting models, providers and managed care companies negotiate myriad permutations of the allocation of risk and responsibility. They carefully specify all sorts of technical details (such as capitation adjustment factors and risk pool residual computations) to assure that the financial arrangements will be mutually acceptable. And negotiation topics change as unforeseen financial, operational, and regulatory issues arise. Contract negotiations are also heavily influenced by the balance of power between the parties.

HMO DELEGATION OF MANAGED CARE FUNCTIONS

Which capitation model is used in contracting largely determines who takes responsibility for related managed care functions. In all these capitation models, the physician organizations, having taken the risk for professional services, usually manage all such care. The physician organizations—not the HMOs—review and authorize services, make determinations of whether requested services are medically necessary, subcontract with ancillary providers, collect claims data, and pay their physician members and other professionals who care for their HMO enrollees. The physician organizations determine how to pay their physician members and subcontracted providers. Physician compensation methods—such as salaries, fee schedules, measures of clinical productivity and patient satisfaction, fixed amounts per case, and subcapitation—vary widely. The HMOs are not involved in determining which compensation methods the physician organizations select. Likewise, when providers assume risk for institutional services, the at-risk providers, not the HMOs, generally review and authorize inpatient stays and coordinate care for patients with complex problems.

There are exceptions. For instance, the HMOs do not delegate appeals of medical necessity determinations

Figure 1
HMO Shared Risk Model: Example of Premium Allocations*



*The dollar amounts shown and the distribution percentages are illustrative only, not based on an actual HMO contract. The figure is illustrative of only one of the contracting models.

when patients or providers contest findings that services are not medically necessary. But, contrary to popular notion, the HMOs have no financial incentive to deny coverage in such appeal cases since the physician organizations bear the liability. The same holds true when an HMO has downloaded risk for institutional services to a provider. The HMO then experiences no financial consequence for its appeal findings. (This balance may enhance patient protection. It can, however, create tension with providers when HMOs make appeal determinations that cost the providers money.)

Despite HMO delegation of many functions to capitated physician organizations, interfaces between HMOs and providers are still complicated and expensive. They both juggle multiple and often conflicting demands from their numerous contracting partners. Both HMOs and providers are struggling to rationalize areas such as data collection, provider credentialing, medical record auditing, drug formularies, patient satisfaction surveys, and medical necessity guidelines. Streamlining is difficult to accomplish because of regulatory compliance issues and because all the participating entities value their operational independence and ability to distinguish themselves in their highly competitive markets. What role, if any, the government might play to support streamlining without stifling innovation is widely debated.

IMPLICATIONS FOR MANAGED CARE LEGISLATION AND REGULATION

Because capitation contracting shifts financial risk and functional responsibilities, and changes the incentives of the parties, it has many policy implications. The following are illustrative.

Some policies, designed to regulate HMOs, can strain patient-physician relationships. For example, capitated physicians report that benefit mandates, such as length of maternity hospital stays, create patient demands for services that may not be needed, placing the physician at odds with patient expectations. A similar dynamic applies when a provider is required to give a patient notice of his or her right to appeal a decision by the provider to move the patient to a different level of care (for example, from the hospital to a nursing home). Such notices, intended to protect patients against unjustified HMO denials of coverage, can engender patient anxiety and distrust even when the clinicians are actually the ones making the treatment plan decisions without HMO involvement.

A second consideration is whether certain legislative and regulatory policies can be meaningfully translated to a capitation context. One example is the question of how relevant performance measures such as HEDIS are at the HMO plan level if the providers belong to many HMOs and the providers control most of the processes that affect HEDIS results. Another example would be some state and the federal provisions requiring plans to disclose (or avoid) certain types of incentives in compensating physicians. The regulations reflect public concern that physicians who have financial incentives tied to limiting service costs might withhold, delay, or deny referrals for needed services. How effective these disclosure provisions will be in general is not yet clear.⁶ In a capitation system, disclosure of how the HMO pays the physician organization may not be relevant to the public concern since the organization may pay its physician members in any of a wide variety of ways.

It is also important to consider who will implement various legislative and regulatory provisions in a capitated context. Capitated provider organizations, not the HMOs, must implement many managed care laws and regulations concerning patient protections, data collection, claims turn-around times, and quality monitoring because the provider organizations generally control the functions involved. How provider operations and costs are affected and what HMOs must do to assure compliance and consistency across providers are important considerations in evaluating whether likely benefits of various provisions are worth the burdens imposed, both on the system and, ultimately, on premium costs to the purchasers and enrollees.

EVOLUTION OF PHYSICIAN ORGANIZATIONS IN CALIFORNIA

In recent years, the trend among physician organizations in California has been toward consolidation into larger-scale organizations of different types. This trend is driven in part by managed care companies pressuring physicians to hold down or reduce reimbursement for their services. The HMOs have been highly successful in this regard for two reasons. First, most physician organizations depend heavily on their HMO revenues. Secondly, the supply of physicians in many locales is sufficient to give HMOs viable options in designing their network constellations.

Physician organizations in California are strongly influenced by HMOs because of high HMO penetration and because of the dominance of a few, very large

HMOs. About 46 percent of the state's total population and about 39 percent of its Medicare beneficiaries are covered by HMOs.⁷ And the state is in the process of moving millions of Medi-Cal beneficiaries under HMOs or capitated physician organizations.⁸ HMOs with over 2 million enrollees in the state include Kaiser, PacificCare, HealthNet, and CaliforniaCare.⁹

Over the past decade, purchasers in California have placed enormous pressure on insurers and HMOs to hold down their plan costs. There has been ferocious price competition among a shrinking number of large HMOs. The result has been unrelenting pressure on physician organizations to maintain or reduce their negotiated capitation rates.¹⁰

In response, physician organizations have been expanding, merging or affiliating with larger organizations.¹¹ This recent trend has taken on many forms, including medical groups growing and merging, IPAs contracting with more physicians and merging, medical groups developing "wrap-around" IPAs to broaden their scale and scope of services, hospital-physician organizations making practice acquisitions and developing management service organizations to help support affiliated IPAs, and PPMCs acquiring individual physician practices and medical groups and affiliating with IPAs. When physicians sell their practices, they usually continue practicing as employees or under contract with the acquiring organization. While physicians thereby lose some degree of independence, they hypothetically gain access to capital and security from affiliating with more financially robust and competitively well-positioned organizations.

The whirlwind rise of three publicly traded PPMCs, each with over a billion dollars in annual revenues, hit a roadblock this summer. One of the companies, FPA Medical Management, Inc., declared bankruptcy. The fallout included precipitous drops in stock prices in that sector and a scramble by HMOs and providers to reconfigure networks affected by FPA's demise. HMOs apparently were able to reconfigure their networks with remarkable speed and little disruption of patient-provider assignments in many locales. To the extent possible, the HMOs assigned affected enrollees to contracts with various other physician organizations that absorbed FPA-affiliated physicians under their purview. Repercussions from that bankruptcy continue, however. For example, many providers reportedly have substantial sums of money tied up in outstanding claims for services rendered to FPA's enrollees on a subcontracted basis.

The health care delivery system in California still

seems to be in great flux. Rumors of additional HMO mergers and provider system consolidations persist. There is growing concern that excessive consolidation among HMOs and among providers may result in anticompetitive business practices and possible antitrust issues, particularly in certain geographic areas. Some industry experts question the long-term prospects of hospital-physician organizations because of conflicts of interest between professionals and institutions in distribution of limited capitation dollars. The fate of the large PPMCs is also uncertain. National scale and access to capital through public equity markets may produce leverage and efficiencies to support continued PPMC development and the PPMCs may be successful in rationalizing care and promoting system efficiencies. Alternatively, as noted in one recent analysis, "The risk is that short-term financial imperatives will impede necessary long-term investments."¹² Volatility in PPMC stock prices is a major threat to their success.

Another industry trend of note is the growth of direct-to-consumer marketing by large provider organizations. Since most managed care companies include most physician organizations in their networks, competition for HMO enrollees and other patients is occurring at the provider level. Providers are therefore increasing their advertising expenditures. In addition, health plan purchasers and HMOs are beginning to profile physician organizations to help enrollees choose their primary care physicians and help providers measure and improve their performance.

THE FORUM SESSION

Brief presentations by the two speakers will be followed by a round-table discussion. The primary intent of the session is to help participants in the Forum's upcoming southern California site visit become familiar with the competitive environment, contracting framework, and current issues in HMO-provider relationships in the region. The session is open to other interested audience members as well, space permitting.

Speakers

Larry Casalino, M.D., Ph.D., is a practicing family physician and clinical assistant professor of medicine at Stanford University. He was the principal investigator on a study entitled "The Evolution of Medical Groups and Capitation in California," which was sponsored by the Henry J. Kaiser Family Foundation and published in September 1997. His doctoral dissertation, "Medical

Groups and the Transition to Managed Care in California," was based on 300 interviews with leaders of HMOs, medical groups, and hospital systems. Dr. Casalino has studied compensation systems for physicians as well as the impact of managed care on physician groups. He has had articles published in the *New England Journal of Medicine*, the *Journal of the American Medical Association*, and *Health Affairs*.

Joan B. Trauner, Ph.D., is a principal in the San Francisco office of Reden & Anders, an actuarial firm that works extensively with HMOs and providers. She was a founder and chief executive officer of PM Squared Corporation, a health care analytics service recently acquired by Reden & Anders. Dr. Trauner served for five years (1991-1996) on the Health Advisory Committee to the California Public Employees' Retirement System (CalPERS). She served in 1992 on the Institute of Medicine's Committee on Employer Health Benefits Reform. From 1979 to 1986, she was a senior researcher and faculty member at the University of California, San Francisco, Institute for Health Policy Studies. Dr. Trauner's publications include an article on physician incomes under fee-for-service versus capitation entitled "Medical Groups in California: Managing Care under Capitation," which appeared in the Spring 1996 issue of *Health Affairs*.

Key Questions

- How are capitation rates negotiated? How do risk pools impact overall returns to physician organizations? What are the advantages of capitation contracting for providers?
- How are physicians currently organized to practice medicine and to contract with HMOs in California? How dominant are the large physician organizations? What are the common ownership structures?
- What are the managed care companies doing to hold down costs in their capitation agreements? How are they building the allegiance of the more powerful provider organizations?
- What financial and operational issues are dominating current negotiations between HMOs and provider organizations? Why?
- How are the physician organizations evolving? Are there major threats to system operations in the foreseeable future?
- What federal health policy concerns are raised by the ongoing shifts in ownership of so many large capitated physician organizations (for example, network

and product stability for beneficiaries, solvency requirements, and antitrust issues)?

- What topics or trends should federal health policymakers consider related to HMOs and capitated physician organizations? Are federal actions needed or desirable to improve market functioning?

ENDNOTES

1. For statistics on enrollment in HMOs and other types of managed care plans, see Hoechst Marion Roussel, *HMO-PPO Digest, 1997*, Managed Care Digest Series, November 1997.
2. For information on projected costs, see Sheila Smith, Mark Freedland, Stephen Heffler, David McKusick, et al., "The Next Ten Years of Health Spending: What Does the Future Hold?" *Health Affairs*, 17:5 (September/October 1998), 128-140. For information on HMO industry income trends, contact Weiss Ratings, Inc., at (800) 289-9222 or see their website: <http://www.weissratings.com>.
3. James C. Robinson and Lawrence P. Casalino, "Vertical Integration and Organizational Networks in Health Care," *Health Affairs*, 15:1 (Spring 1996), 12-13.
4. For capitation purposes, premium is calculated net of broker fees, taxes, and other so-called "plan factors" related to member demographics and benefit plan designs.
5. A "limited Knox-Keene license" allows the provider organization to take global risk for all medical services but not to market an HMO plan directly to purchasers.
6. Fred J. Hellinger, "Regulating the Financial Incentives Facing Physicians in Managed Care Plans," *American Journal of Managed Care*, 4:5 (May 1998), 673.
7. See Hoechst Marion Roussel, *HMO-PPO Digest 1997* for state-specific HMO penetration rates. Information on Medicare enrollment is from Joel Menges, Nancy Beronja, Phyllis Costanza, June Eichner, and Daniel Wallitt, "Medicare Managed Care Enrollment: A Detailed Assessment of 1995-1997 Growth Patterns," Lewin Group, April 1998.
8. Bureau of National Affairs, "California Shows Progress with Managed Care Experiment," *BNA's Managed Care Reporter*, 4:32 (August 12, 1998), 809.
9. "Fact Sheet: 20 Million Californians Belong to a Health Plan," California Association of Health Plans, enrollment figures, March 31, 1998.
10. Joan B. Trauner and Julie S. Chestnutt, "Medical Groups in California: Managing Care under Capitation," *DataWatch, Health Affairs*, 15:1 (Spring 1996), 161.

11. Lawrence P. Casalino and James C. Robinson, *The Evolution of Medical Groups and Capitation*, report sponsored by the Henry J. Kaiser Family Foundation, distributed by the California HealthCare Foundation, Oakland, California, September 1997.

12. James C. Robinson, "Financial Capital and Intellectual Capital in Physician Practice Management," *Health Affairs*, 17:4 (July/August 1998), 54.