Scale And Structure Of Capitated Physician Organizations In California

Market pressures have forced these organizations to change with the times, according to these survey data.

by Meredith B. Rosenthal, Richard G. Frank, Joan L. Buchanan, and Arnold M. Epstein

ABSTRACT: Physician organizations in California broke new ground in the 1980s by accepting capitated contracts and taking on utilization management functions. In this paper we present new data that document the scale, structure, and vertical affiliations of physician organizations that accept capitation in California. We provide information on capitated enrollment, the share of revenue derived by physician organizations from capitation contracts, and the scope of risk sharing with health maintenance organizations (HMOs). Capitation contracts and risk sharing dominate payment arrangements with HMOs. Physician organizations appear to have responded to capitation by affiliating with hospitals and management companies, adopting hybrid organizational structures, and consolidating into larger entities.

For a number of years researchers have recognized California as the cradle of a unique brand of managed care in which physician organizations assume financial risk and are delegated authority for managing the care of a population of health maintenance organization (HMO) enrollees.1 To many, the notion of a system in which autonomous physician organizations rather than HMOs control a broad range of utilization management decisions holds great appeal. Wall Street, too, was enamored of the prospect of “physician-managed” care and provided capital that accelerated the development of a new industry (physician practice management, or PPM) to support medical groups and independent practice

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associations (IPAs) in managing capitated contracts. Recently, however, news out of California has taken a decidedly negative turn, with dire reports about the financial solvency of physician organizations and the viability of the delegated model.²

In California both health care providers and policymakers have begun to take steps to respond to the apparent crisis. There is a clear need to take stock of the delegated model and the physician organizations that accept capitation contracts. This information bears on the future shape of managed care in other markets as well, which have to varying degrees adopted capitation and delegation of utilization management as cost containment strategies. In this paper we describe the scale and structure of capitated physician organizations in California, the nature of their contracts with HMOs, and their affiliations with hospitals and management companies.

**Data And Methods**

We set out to survey all of the physician organizations in California that contract with PacifiCare Health Systems, the third-largest health plan in California and the fifth-largest in the nation. While the PacifiCare network was our starting point for identifying groups that accept capitation, our data relate to all of the contracts that are held by the physician organizations, which typically hold about ten HMO contracts. The physician organizations that contract with PacifiCare provide care for about 80 percent of all Californians that obtain their care through the delegated model.

To develop the survey instrument, we reviewed prior surveys of managed care and physician organizations and other relevant literature. We consulted with representatives of important organizations in the industry, including the American Medical Group Association, the National IPA Coalition, and the California Medical Association. We also carried out a series of case studies of physician organizations selected to represent the diversity of our sample.³

After identification of the physician organizations by PacifiCare, interviewers contacted each organization’s medical director or chief executive officer (CEO) by mail and then made at least ten attempts to schedule and administer a telephone survey. Study participation involved a forty-five-minute structured telephone interview. The study was carried out between May 1999 and June 2000. A 97 percent response rate was obtained by our interviewers; only 4 of 157 potential respondents declined to be surveyed for the study.

The survey directed respondents to use the full year 1998 as the frame of reference for our questions, which addressed the following domains: structure and contracts, human resources, governance, financial incentives, utilization management, quality management,
and information systems. Here we report on findings from the domains of structure and human resources.

**Survey Results**

- **Structure and scale of physician organizations.** We identify three types of physician organizations: medical groups, medical groups with an IPA wraparound, and IPAs. Medical groups are highly integrated organizations in which physicians are employees or participants in a partnership arrangement. With few exceptions, physicians belong to only one medical group and practice together in facilities (of which there are often several) owned and managed by the group. In contrast to medical groups, IPAs are decentralized physician organizations. Physicians typically have nonexclusive contractual relationships with IPAs and manage their own offices independently.

  Our third category is a hybrid type: the medical group with IPA wraparound (simply “wraparound” hereafter). In the wraparound there is a core medical group that both delivers services and manages an IPA. In some cases, the wraparound may consist of two distinct legal entities with separate bottom lines. For the purposes of HMO contracting decisions and affiliations with hospitals and management companies, however, the entities we have identified as wraparounds operate as a single unit. To avoid double-counting a single set of organizational decisions, we have chosen to view each wraparound as a single entity. Where appropriate, we note how our results would be affected by considering each wraparound as an unrelated medical group and IPA. In addition, we show the numbers of primary care and specialist physicians separately for the core and IPA parts of the wraparound in Exhibit 1.

  More than half of the physician organizations in 1998 were IPAs (Exhibit 1). Only about 15 percent of the organizations were pure medical groups; the remainder took the wraparound form (47 of 153 entities). If we were to treat wraparounds as two separate entities, one medical group and one IPA, we would find that about two-thirds of the organizations were IPAs and one-third, medical groups.

  The most striking feature of capitated physician organizations in California is their sheer size in terms of numbers of physicians. Across all types, they averaged 343 total physicians each. Numbers ranged from 5 to 2,600, with a median of 216. Most, however, were large: Three-quarters of the organizations consisted of at least fifty physicians in 1998.

  Wraparounds were the largest entities in terms of total physicians, with 83 core physicians plus 296 IPA physicians on average.
Comparing the components of the wraparound to pure medical groups and IPAs, we find that the wraparound relationship is undertaken by smaller-than-average medical groups and IPAs. IPAs were a close second to.wraparounds in terms of scale, averaging 364 member physicians. Medical groups, while smaller than their wraparound and IPA counterparts, were quite large by national standards. According to the American Medical Association (AMA), the average U.S. medical group consisted of nine physicians in 1996.4 The average medical group in our sample contained 209 physicians (the median was 93).

Capitated physician organizations in California are predominantly multispecialty. Only three of the 153 organizations were restricted to primary care physicians; none excluded such physicians. Nationally, about 70 percent of medical groups are single-specialty.5

The impetus toward organizations of a larger scale is apparent not just from the cross-sectional description in Exhibit 1, but also from reports of merger activity. More than half (56 percent) of the groups that we interviewed participated in some type of merger or acquisition between 1996 and 1998. Mergers were somewhat less common among IPAs than among other organizational types.

■ Capitated enrollment. The average total capitated enrollment for physician organizations in our sample was 51,538 (Exhibit 1). There was a wide range in capitated enrollment, from about 700 to

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EXHIBIT 1
Distribution Of Physician Organizations In California, By Size And Model, 1998

<table>
<thead>
<tr>
<th>Physician organizations</th>
<th>Medical groups</th>
<th>IPAs</th>
<th>Wraparounds</th>
<th>All types</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Core</td>
<td>IPA</td>
</tr>
<tr>
<td>Primary care physicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>25</td>
<td>81</td>
<td>47</td>
<td>47</td>
</tr>
<tr>
<td>Median</td>
<td>57</td>
<td>111</td>
<td>41</td>
<td>34</td>
</tr>
<tr>
<td>Specialists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>152</td>
<td>253</td>
<td>41</td>
<td>261</td>
</tr>
<tr>
<td>Median</td>
<td>40</td>
<td>180</td>
<td>6</td>
<td>147</td>
</tr>
<tr>
<td>Total physicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>209</td>
<td>364</td>
<td>83</td>
<td>296</td>
</tr>
<tr>
<td>Median</td>
<td>93</td>
<td>236</td>
<td>33</td>
<td>170</td>
</tr>
<tr>
<td>Capitated lives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>49,708</td>
<td>43,779</td>
<td>66,194</td>
<td>^a 51,538</td>
</tr>
<tr>
<td>Median</td>
<td>41,900</td>
<td>27,500</td>
<td>34,750</td>
<td>^a 31,000</td>
</tr>
</tbody>
</table>

SOURCE: Harvard University survey sponsored by the California HealthCare Foundation.
NOTES: Wraparounds are treated as single entities for the purpose of enrollment. However, we show numbers of physicians separately for the core medical groups and independent practice associations (IPAs) within wraparounds. The total number of organizations counts the wraparounds only once.

^a Capitated lives for wraparound IPAs are included in the figure listed under “wraparound core” (see Notes).
700,000, with a median of 31,000. As was the case with the number of physicians, the wraparounds had the greatest total capitated enrollment. Medical groups, however, were larger on average by this measure than IPAs. Because there are more than three times as many IPAs in the sample as medical groups, however, IPAs account for just under half of all capitated patients.

The physician organizations accept capitation contracts that cover enrollees in commercial, Medicare, and Medi-Cal (California Medicaid) plans. Roughly 80 percent of all capitated enrollees cared for by these groups are in commercial plans. This figure understates the importance of Medicare in terms of capitated revenue, however, since Medicare capitation rates are several times higher than commercial rates.

**Affiliations.** The ability of physician organizations to accept and successfully manage capitation contracts is partly a function of their scale, but it may also be enhanced by their ties to hospitals and PPM companies. Such affiliations offer physicians access to external risk sharing, financial capital, and management expertise. Whether affiliations take the form of ownership, long-term contracts, or informal arrangements is driven by a number of factors including regulatory constraints and tax considerations. Rather than restricting our analysis to legal integration (ownership), we describe the prevalence of self-reported affiliations of any type.

**Hospitals.** Historically, most physician organizations in California have maintained their independence from hospitals. Moreover, California law makes the acquisition of physician organizations by hospitals challenging. Hospitals other than academic medical centers generally must set up a “medical foundation” to purchase physician organizations. Only about 20 percent of physician organizations overall were affiliated with a medical foundation in 1998, and this was four times as likely among medical groups as among IPAs (Exhibit 2).

While vertically integrated entities are still relatively rare, many physician organizations maintain close ties to one or more hospitals. The use of a preferred hospital can be advantageous for a physician organization in managing use of hospital services because of increased leverage and the potential for improved coordination (for example, for discharge planning). Overall, 92 percent of physician organizations indicated that they channeled their admissions to one
or several preferred hospitals (Exhibit 2).

Management companies. In the 1990s management service organizations (MSOs) and PPM companies proliferated in California. These firms range in complexity and sophistication from the incorporation of the back-office functions of a single group to publicly traded entities that manage practices across the nation. Nearly 90 percent of the physician organizations had either an ownership or a contractual relationship with an MSO or a PPM in 1998 (Exhibit 2). This was most common for IPAs.

Importance and scope of capitated contracts. We are interested in understanding the financial aspects of the contracts that the physician organizations hold with health plans for two intertwined reasons. First, we want to assess how much risk these entities accept for the cost of care. We judge risk in part by the scope of services included in capitation contracts. Second, we want to know how important these contracts are to the physician organizations by looking at what share of their revenue takes this form. The share of revenue from capitation tells us how dependent the organizations are on this type of contract and thus how strongly motivated they will be to adapt organizational features to capitation incentives.

We asked the physician organizations to break out their revenue according to the following methods of payment: discounted fee-for-service (FFS), FFS with withhold, professional capitation, professional plus ancillary capitation, and global capitation (Exhibit 3). Overall, 84 percent of patient care revenue for the groups in our sample came from some kind of capitation contract. The majority of the capitated revenue came from contracts in which professional or professional plus ancillary services were included in the capitation payment and hospital risk was shared rather than fully delegated to the physician organization. The inclusion of full hospital risk in the scope of the capitation payment (“global capitation”) was less common. This latter type of contract constituted about 15 percent of revenue on average and was concentrated among a minority of phy-
The primary difference in revenue composition by organizational form is between IPAs and the more integrated physician organizations. On average, 25 percent of revenue for medical groups was derived from FFS contracts, similar to the 23 percent for wraparounds. By contrast, the IPAs in the sample received only 9 percent of their patient care revenue from FFS contracts. This reflects the fact that many IPAs exist primarily to negotiate and manage capital contracts for their member physicians, who deal directly with health plans for their FFS clients.

As noted above, shared risk arrangements for hospital costs typify capitation contracts in California. Risk sharing for hospital costs is generally structured as a “risk pool” in which a spending or utilization target (such as bed days) is set and cost savings or overruns relative to the target are shared between the physician organization and the HMO (and possibly a hospital) according to a predetermined formula. This is also the case for pharmacy costs. Sixty-three percent of the groups that we interviewed had some type of shared risk arrangement for their pharmacy contracts.

**Discussion**

Our study underscores several important features of physician organizations that are not well documented in the literature. First, we found a substantial number of medical groups undertaking a new business strategy that involves managing their own IPA: the so-called wraparound.

Wraparounds serve a number of functions, many of which involve exploiting economies of scale while maintaining the flexibility that large staff-model organizations lack. Three distinct rationales for group practices to develop wraparound networks are commonly
“Pharmacy and hospital risk sharing have declined as a result of the consumer and provider backlash in California.”

offered. The first is to channel volume through a limited number of specialists. Concentrating referral volume should improve the negotiating position of the group, reduce transaction costs, and facilitate clinical coordination between primary care physicians and specialists. For a medical group that accepts professional or global capitalism, outside referrals can be a major source of costs. Indeed, out-of-group referrals are 18 percent of professional spending in medical groups and only 10 percent for wraparounds, while the wraparound itself absorbs about 43 percent of the revenue that flows into the medical group. The second rationale for a wraparound is to improve geographic coverage of the group in terms of primary care physicians and/or specialists. A third reason that medical groups have constructed their own IPAs is to open up new channels for referrals into the group. That is, the wraparound can be designed to include primary care physicians who provide business to specialists employed by the medical group (much like the way hospitals elsewhere have purchased primary care practices to “feed” their beds).

The dominance of less integrated organizational forms (IPAs and wraparounds) mirrors the structure of HMOs today, where staff-model organizations are a shrinking minority. The same factors that have led to the dominance of IPA and network-model HMOs are likely responsible for this pattern: the desire of consumers to have choice of providers and sites of care, the desire of physicians to operate independently (that is, not as employees), and the diseconomies of scale associated with integrated physician practice.

Compared with the nation as a whole, capitated physician organizations in California appear to be larger and more likely to be multispecialty. Both of these structural features may reflect the demands of managing capitation contracts. Because more than 80 percent of their patient care revenue derives from capitated sources, risk spreading is critical to these organizations. Similarly, multispecialty organizations may be in a better position to control health care spending than single-specialty organizations are, because of improved coordination.

There has been great concern in California about the scope of risk sharing with physician organizations. Our results indicate that most of these organizations accepted risk for both hospital care and pharmacy in 1998. Pharmacy risk sharing in particular has been a source of great controversy because of its association with heavy
financial losses among capitated physician organizations in California. First, pharmaceutical spending is growing rapidly everywhere; nationally it grew by 18 percent in 1999. Second, physician organizations may not have full control over pharmacy utilization; they often do not get detailed utilization data, and other entities (primarily pharmacy benefit managers, or PBMs) control formulary design.

There have been substantial changes in risk-sharing arrangements between HMOs and physician organizations in the short time since this study was undertaken. Both pharmacy and hospital risk sharing have been greatly reduced as a result of the consumer and provider backlash in California against the use of these payment strategies. This is not the case for professional services, for which capitation remains prevalent in California.

Our study confirms prior research on California physician organizations in showing that they are large, multispecialty entities that are deeply involved in the business of managing capitated contracts. In fact, our results amplify these conclusions: We found California physician organizations to be larger and taking more risk for the cost of care than prior surveys have found. These findings may reflect two related trends at the end of the 1990s in California: (1) consolidation of physician organizations into larger entities, and (2) increased use of risk sharing and delegation of utilization management.

Our results should be interpreted in light of several strengths and weaknesses of the study. Its primary strengths are the high response rate (97 percent) and the detailed data we were able to collect from knowledgeable respondents. In addition, because California is a bellwether state for managed care and for the “delegated model” in particular, our study gives an excellent picture of what is happening at the cutting edge of provider capitation. On the other hand, because California is an outlier relative to the rest of the nation, these results may not be generalizable to other markets. The other primary weakness of the data has been hinted at above: The market dynamics in California render even the most current survey data somewhat out of date.

Physician organizations in California have undergone a number of structural transformations as a result of market pressures. The formation of wraparounds as a strategy for growth and cost containment is the most notable of these changes. In addition, we found evidence of mergers and acquisitions resulting in larger organizations than previously noted. Risk sharing is pervasive, in terms of both the share of revenue from capitation and the scope of services covered by risk-sharing arrangements. Two key factors examined here mitigate the risk exposure of physician organizations: their affiliations with MSOs, PPMs, and hospitals; and their large size.
Despite these factors, there is still a good deal of financial pressure on physician organizations in California. During the past several years a substantial number of physician organizations and PPMs have failed. From 1998 through 2000 thirty-one medical groups or IPAs in our sample went out of business, along with (and often because of) the failure of three major PPMs. These failures have had a wide range of immediate and long-term effects. In terms of immediate effects, when medical groups fail, physicians may be left without a practice and patients without a source of care. IPA (and some PPM) failures most directly affect financial flows and contractual relationships, since physicians have independent practices. In the longer term, the failure of physician organizations in California appears to be changing the nature of risk arrangements and stimulating more stringent regulatory policy toward physician organizations and HMOs that use the delegated model.

Whether and how physician organizations will thrive under capitation in the future is a pressing question in and beyond California. What is needed, in particular, is some understanding of what predicts the success or failure of a risk-bearing physician organization. While no causal relationship can be established from our data, and the number of failures is too small even to detect statistical associations, there are some apparent patterns among these failures. Failed physician organizations were more likely to be IPAs, less likely to be affiliated with a foundation, and somewhat larger than average (within their organizational type). These data provide a starting point for important future research on the delegated model.

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NOTES


5. Ibid.


7. Specifically, we asked, “Is your physician organization affiliated with: a. an MSO/PPM; b. a foundation; c. a preferred or primary hospital(s)?”


9. In California, physician organizations must obtain regulatory approval, known as a limited Knox-Keene license, in order to accept global capitation.


14. Two of the PPM failures affected many of the same physicians. About half of the approximately twenty medical groups and IPAs in our sample that were affiliated with MedPartners (which dissolved in 1999) were absorbed by KPC Medical Management, which filed for bankruptcy in late 2000. Only two physician organizations in our sample closed as an immediate result of the MedPartners failure. Fifteen medical groups and IPAs dissolved as an immediate result of the KPC bankruptcy.