

# **THE EVOLUTION OF MEDICAL GROUPS AND CAPITATION IN CALIFORNIA**

LAWRENCE CASALINO, MD, PhD  
JAMES ROBINSON, PhD, MPH

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## **THE AUTHORS**

Lawrence Casalino is a Clinical Assistant Professor of Medicine at Stanford University. He was principal investigator on this project and lead writer of this report. James Robinson is a Professor in the School of Public Health at the University of California, Berkeley, and Chair of the PhD Program in Health Services and Policy Analysis at that institution. He provided extensive consultation throughout the research and writing of this report.

## **EXECUTIVE SUMMARY**

### **Introduction**

Managed care in California operates through medical groups and through physician-organized Independent Practice Associations (IPAs). Health Maintenance Organizations (HMOs) pass most of the financial risk for the costs of medical care and delegate most of the responsibility for managing care to these physician-controlled organizations. The California model differs from that common elsewhere in the United States, in which physicians are employed by HMOs or contract as individuals within HMO organized IPAs.

Large California medical groups and IPAs have more negotiating power with HMOs than do individual physicians. They also develop expertise in managing care—expertise which is developed within HMOs in states which lack organized physician groups. In California, most of managed care's effects on the quality and cost of medical care are determined by the actions of large medical groups and IPAs.

Capitated physician groups are a new type of organization, with new capabilities. Debates over managed care often miss this fundamental fact. These new organizations can be understood as a new tool, one which has the potential for beneficial or harmful effects on patients' health, depending on how it is used.

Ever since the publications during the 1930s of the Committee on the Costs of Medical Care (e.g., Committee on the Costs of Medical Care, 1932), medical reformers have tried to create a system in which physicians would work together within groups to create innovative ways to care for the groups' populations of patients. Their efforts were largely unsuccessful until capitation and managed care were developed and began to drive the formation of physician groups in California.

These capitated physician groups are a new type of organization, with new capabilities. Debates over managed care and capitation often miss this fundamental fact. These organizations can be understood as a new tool, one which has the potential for beneficial or harmful effects on patients' health, depending on how it is used. How have the groups grown and taken control of utilization management? Who has owned them, and how have they been governed? And why have these successful organizations been selling their practices to extremely large physician practice management companies such as MedPartners?

### **Description of the Study**

In order to provide the data to answer these questions, we sketched the rise of five large California medical groups—Bristol Park, Friendly Hills, HealthCare Partners, Mullikin, and Palo Alto—between 1975 and 1996. With the exception of the Palo Alto Medical Clinic, these groups were small when they signed their first managed care contracts. In the two decades since, while most California physicians reacted to the emergence of the HMO industry first with indifference, then with anger, and finally with a rush to “grab a seat on the managed care train before it leaves the station,” the physicians in these five groups gradually came to see managed care as more opportunity than threat. While their peers strove to continue with business as usual, these five groups developed

strategies and capabilities to compete successfully in the dramatically changed market. They did more than just respond to changes in their environment, they cooperated with each other and with HMOs to create a new industry.

In 1979, these five groups had a total of 192 physicians (126 of whom were in the Palo Alto Medical Clinic) and 20,606 HMO enrollees; by 1994, they had 928 physicians and 906,932 HMO enrollees (Robinson and Casalino, 1995). In this study, we tracked changes in the groups' growth; governance; relationships with each other, with HMOs, and with hospitals; methods of physician payment; and, most of all, management of care. In addition, we examined the increasing pressures from the evolving California managed care market which led to the sale of the assets of four of these five groups to much larger, capital-rich, non-physician-controlled organizations.

We selected the five groups profiled in this report because of their size, because they are among the best-known in the state, and because their individual histories illustrate important aspects of the experience of medical groups during the growth of managed care in California. The report, originally commissioned by the Henry J. Kaiser Family Foundation, is based on 75 interviews we conducted in California during 1996 and early 1997, and on documents obtained from the groups and from a variety of other sources. We also drew on nearly 200 interviews conducted during 1994 and 1995 with managed care leaders throughout the state (made possible by a grant from the Robert Wood Johnson Foundation), and on extensive review of the trade literature.

## **Highlights of the Study Findings**

### *Capitation: Catalyst of Physician Practice Reorganization*

Capitation as designed in California should be understood not simply as a payment mechanism but also as a force for the reorganization of physicians from solo and small group practices into larger groups. When the new California HMOs were created in the mid-1970s, they quickly signed contracts with medical groups and, soon after, with physician-organized IPAs rather than contracting with individual physicians. Though most physicians were not interested at the time, the expansion of HMOs and the use of capitation as a payment method gave individual physicians a strong incentive to join medical groups or IPAs, and gave medical groups and IPAs a strong incentive to grow. Large physician organizations are more likely to obtain HMO contracts and negotiate them on reasonable terms. They can spread the financial risk of accepting capitation over large numbers of physicians and patients. They have both greater incentive and greater resources available to invest in developing systematic processes for reducing the cost and increasing the quality of care.

Capital for the rapid expansion of California's medical groups and HMOs came from the reduced rates they negotiated with hospitals and, especially, from a dramatic reduction in hospital utilization. From the start, the typical HMO contract gave a medical group a capitated rate for its professional services and created an annual "hospital risk pool" to pay for hospital services for the group's patients. Any surplus remaining in the pool was split more or less equally between the medical group and the HMO. Over the past 20 years, these medical groups reduced hospital days per thousand per year to 137 for non-Medicare patients and 900 for Medicare patients—one-third of pre-managed care rates. Other successful California medical groups achieved similar savings.

### *How Do the Groups Manage Care?*

Did the groups manage to lower hospitalization so dramatically at the expense of quality, and/or because they enrolled healthier patients? Or have they actually succeeded in creating more effective ways to manage care? Data to provide definitive answers to these questions do not exist, it is possible to describe the processes developed by these five groups. These processes appear to have the potential to lower costs while simultaneously increasing quality.

From their very first contracts, California HMOs have delegated utilization management to these medical groups. The physicians in the group create their own processes for managing care, rather than having decisions imposed upon them by a distant, anonymous third party. These processes are evolving:

- from a focus on reducing costs to a focus both on costs and on the improvement and documentation of quality.
- from utilization review, the micro management of a physician's clinical decisions about individual patients—to utilization management and quality improvement, the systematic attempt to improve the efficiency and quality of care of a group of physicians for the population of patients served.
- from creating savings and profits from relatively simple measures, e.g., not hospitalizing patients with low back pain—to attempts to “re-engineer” the process, and therefore the cost structure, of medical care.
- from defining quality as how well an individual physician cares for an episode of illness in an individual patient to defining it to include how well a group of physicians work together to improve the health of an entire patient population.

Much of this movement has occurred during the past five years. It has been driven by purchasers' increasing demands for data on quality, by the groups' accumulated and shared learning about how to manage care, and by the fact that the groups had grown large enough to have the resources and economies of scale necessary to establish utilization management and quality improvement systems, including the purchase of sophisticated computer systems.

### *Full Risk Capitation*

As they became more skilled at utilization management, many large California medical groups negotiated HMO contracts that increased the number of medical services for which they were capitated. From the mid-1980s on, they sought to be capitated for hospital as well as for physician services. During the 1990s, they have moved closer to “full risk capitation” (also called “global capitation”) in which an HMO passes on to a provider organization all or most of the amount of the premium dollar allocated to pay for physician services, including hospital, skilled nursing facility, and home health, and for ancillary services, including laboratory and ambulance, durable medical



equipment, and sometimes a part of pharmaceutical costs.

Full risk capitation gives a medical group control over approximately 80% of the premium dollar, more leverage in negotiating contracts with hospitals, specialists, and ancillary service providers, more cash flow to invest in creating utilization management and quality improvement systems, the opportunity to retain all the profit from savings these systems generate, the opportunity to develop wider expertise in managing care, and the opportunity to better coordinate care and to allocate dollars where they will have the most impact on patients' health.

Full risk capitation has the potential to be beneficial for society as well as for medical groups. In addition to making possible better coordination of care and rational allocation of resources, full risk capitation could reduce administrative complexity and costs, provide clearer assignment of accountability for patients' care, and, for better or for worse, encourage the organization of physicians into large groups.

But full risk capitation carries potential dangers along with the potential rewards. Though the medical groups profiled in this report have been successful in their movement toward full risk capitation, most medical groups still lack the size, capital reserves, utilization management expertise, information systems, and efficient governance necessary to succeed at this high-stakes venture. Even if groups have the capabilities needed to handle full risk, patients will benefit only if the environment of regulation and market incentives in which the groups operate rewards groups for increasing the quality of care, and not simply for reducing costs.

#### *How Do the Groups Pay Their Physicians?*

The five groups profiled in this report do not use capitation to pay their own physicians. During the era of fee-for-service payment, they typically paid individual physicians based on the amount billed by each. As more of the groups' income came through capitation, they gradually began implementing payment methods based on a simple idea, but one that did not make economic sense in a fee-for-service practice. They began by outlining those things they wanted their physicians to do well, and then moved toward structuring payment methods to encourage continual performance improvement in those areas.

The groups still base a large proportion of each physician's compensation on the amount of clinical work done by that physician, but increasingly a physician's compensation also varies by how well he or she scores on measures of quality of care, patient satisfaction, peer and staff review, and service to the organization. In these five groups, on average only 3% of a physician's income is determined by measures of the costs of care he or she generates.

Individual physicians do have additional incentives to control costs: first, pressure from peers and superiors within the group; and second, the fact that a capitated medical group increases its profits as it tightens control of costs. This incentive, however, is much weaker than when a physician is capitated as an individual or as part of a small group, because in large medical groups the actions of any one physician cannot greatly increase profitability, and one physician's share of any increase in profits will not be large.

## *Growth and Sale of the Groups*

During the 1980s, California's capitated medical groups were able to grow incrementally, hiring new physicians and opening new offices with little risk and little capital. HMO growth was so rapid that there was a steadily increasing supply of patients to support the groups' expansion. But in the early 1990s, increasing saturation of the HMO market in the groups' core geographic areas, increasing competition from IPAs, and a recession in Southern California stalled the growth of both HMOs and medical groups. California's HMOs had become very large and were using the capital gained by the conversion to publicly traded corporations to grow even larger. Competition among the HMOs for market share, as well as pressure from the Pacific Business Group on Health (PBGH—a coalition of large employers) and the California Public Employees Retirement System (CALPERS) forced the HMOs to cut premiums and to pass these cuts on in reduced payment rates to medical groups.

The groups believed that they had to grow larger—and to do so quickly—if they were to maintain some negotiating leverage with HMOs. They also realized that larger medical groups would be valued more highly by investors, should a group's physicians decide to sell. For the first time, the groups began to grow by acquiring or merging with other medical groups, to open practices in each others' core geographic areas, and to make plans to move into distant geographic areas where lower HMO penetration and the lack of managed care expertise might make it possible to generate the levels of growth and of profits of the previous golden decade in California.

This rapid growth required more capital than the groups possessed. There were other reasons as well for the groups to surrender their long-cherished independence and sell to capital-rich organizations. Some of the groups had significant—and unfunded—buy-out commitments to partners who were nearing retirement age. Others felt it was important to become part of a larger organization in order to gain some measure of security in the increasingly turbulent and unpredictable managed care industry. Finally, sale of a group would yield large sums of money for its physicians and executives, especially those who had worked longest to make the group successful. By 1996, only HealthCare Partners remained independent. Bristol Park and the Palo Alto Medical Clinic had sold their assets to nonprofit hospital systems, and Friendly Hills and Mullikin had sold to publicly traded physician practice management companies (PPMs).

## **Conclusions**

Capitated medical groups are a new kind of organization, with new capabilities. They provide a potential tool—an opportunity for innovation and improvement—which simply did not exist in the fee-for-service, solo, and small group practice system of medical care.

Rather than trying to micro-regulate medical care, it would be preferable to be clear about the systemic goal: to have groups of physicians caring for populations of patients and competing on both costs and quality, and to try to devise contracts and regulations which would facilitate the development of such a system. In particular, attention should be paid both to structuring incentives and to the types of physician organizations that are emerging.

### *Structuring Incentives*

1. HMOs and medical groups should not be penalized for excelling in the care of seriously ill patients. Therefore, risk adjustment of payments and of quality measurements should be done—insofar as it is feasible—both between purchasers and HMOs, and between HMOs and medical groups.
2. Quality measurement systems should be devised to minimize the possibility of unintended consequences, i.e., of quality of care decreasing in the areas which are not being measured.

### *Focus on Types of Physician Organization*

1. Research and debate concerning managed care should specify both who is paying capitation to whom and what type of physician organization is involved.
2. Purchasers, regulators, and researchers should have a clear understanding of the many ways in which physician practice may be organized.
3. If quality measurements and risk adjustment can be made with reasonable credibility, and if physician organizations are already bearing most of the financial risk for medical care and are performing their own utilization management, then more of the risk and reward for efficient, high quality performance should be focused at the level of the physician organization, rather than at the HMO level.
4. Purchasers and regulators should have a clear understanding of potential advantages and disadvantages of full risk capitation of physician groups, and of the capabilities required for a group to manage full risk contracts.

The favorable combination of circumstances which made possible the creation of California medical groups like those profiled in this report probably do not exist elsewhere in the United States at this time. During the next five to ten years, the growth of managed care will lead to some form of organization of physician practice in metropolitan areas throughout the United States, but physicians who want to do this organizing must compete with HMOs, with hospital systems, and with PPMs, all of which have far more capital and administrative expertise than physician groups.

If California's large medical groups—Mullikin at the time of its sale had more capitated patients than many HMOs around the United States—are almost unanimously choosing to join publicly-traded or hospital-managed PPMs, it is difficult to see how physicians elsewhere would organize successfully independently of these large organizations. Indeed, PPMs like Mullikin-MedPartners and San Diego-based FPA, which gained their experience with managing capitated contracts in California, are now using it to organize physicians in other states, bringing the organizational model of full-risk capitation and medical group management of utilization with them. The ultimate form and degree of success of these organizations, and the effects that they will have on the quality and costs of medical care, remain uncertain.

## STUDY PURPOSES AND APPROACH

Large capitated medical groups have had a critical role in the development of the HMO industry in California, yet little is known about this role or about their current operations. With funding from the Henry J. Kaiser Family Foundation, we conducted case studies during 1996 and early 1997 of five of the most significant groups in the state. We selected these five groups from thirteen prominent California medical groups with which we had conducted interviews and site visits during 1994 and 1995 in research supported by the Robert Wood Johnson Foundation. During those years we also interviewed executives in IPAs, employer health care purchasing coalitions, HMOs, and hospital systems, as well as government regulators, lobbyists, bankers, stock analysts, and consultants. The nine other groups were the MedClinic in Sacramento, the Good Samaritan and San Jose Medical Groups in Silicon Valley, the Scripps and Rees-Stealy groups in San Diego, the Pacific Physician Services and Beaver Medical groups in the Inland Empire east of Los Angeles, and the Facey and Harriman-Jones groups in the L.A. area. By 1995, these thirteen groups were responsible for approximately 1.7 million capitated HMO enrollees in California, of which the five groups profiled in this manuscript accounted for approximately one-half.

We chose to concentrate on these five because of their size, because they are among the best-known in the state, and because their individual histories illustrate important aspects of the experience of medical groups under managed care in California. We made numerous site visits and conducted 75 interviews with leaders of these groups and with the groups' "rank-and-file" physicians and non-physician utilization and quality management staff. We also interviewed HMO and hospital executives concerning their relations with these medical groups, and examined documents supplied by the groups, by the Unified Medical Group Association (the trade association for capitated medical groups), and by other sources.

Mullikin is the largest group in the state (after the Permanente Medical Groups) and has been the most aggressive in seeking to grow; in 1996 it merged with Alabama-based MedPartners to form the largest physician management company in the nation. HealthCare Partners is also very large, and is the only one of the five groups which has remained independent. Bristol Park is notable for being an exclusively primary care group; Palo Alto for being a traditionally specialist-oriented, highly prestigious group that successfully made the transition to managed care; and Friendly Hills for its tight physician-hospital integration. Four of the five groups are based in the Los Angeles area, the cradle of managed care in California. HealthCare Partners was created by physicians staffing an inner-city emergency room; the Palo Alto and Bristol Park groups are based in populous, affluent suburbs; Friendly Hills and Mullikin grew from working and lower middle-class suburbs southeast of Los Angeles.

## **INTRODUCTION: A SUMMARY SKETCH OF THE GROWTH OF CAPITATED MEDICAL GROUPS IN CALIFORNIA**

“A medical group contracting with an HMO is like a man holding a panther by the tail—  
as long as you keep stroking the panther, everything is fine,  
but if he starts getting frisky, you’ve got him by the tail and you can’t let go.”

These ambivalent—and prescient—words were quoted in 1980 by John Hammett, the Bristol Park administrator (Unified Medical Groups, *Network News*), when most of the panthers were still cubs, and most of the California medical groups contracting with HMOs were still small. For the past two decades, California HMOs and their contracting medical groups have been engaged in an intense interaction—both cooperating and competing—which resulted in rapid growth for each and in shaping the contours of the new managed care industry.

### **The 1970s: Medical Groups Cooperate in Creating New HMOs**

The threat of competition from the expanding Kaiser Permanente HMO and the passage, in 1973, of the federal HMO law led directly to the creation of California’s new HMOs, and to the willingness of some medical groups to sign contracts with these HMOs. According to John McDonald, CEO of Mullikin Medical Center, “Our concern was that Kaiser would start mandating and take patients away. Our moves at the time were definitely defensive. We were afraid of the mandate as a threat, rather than an opportunity.” The HMO law included a provision mandating that large employers offer a federally qualified HMO.<sup>1</sup> Particularly in Southern California, many of the medical groups’ patients worked for large employers, notably in the aerospace industry.

Blue Cross of Southern California, which was concerned both about Kaiser and about the potential effects of the HMO law, created CommuniCare (later named Health Net), an HMO which had few patients until, after months of negotiations with a number of Los Angeles area medical groups, it signed a contract in 1975 with a new nonprofit organization called the Unified Medical Groups (UMG). CommuniCare made capitation payments to the UMG, which then distributed the money to medical groups which contracted with UMG to care for CommuniCare’s patients. During the first few years, Blue Cross helped fund UMG’s operating expenses. The medical groups, for their part, wanted the new HMO to succeed. James Hillman, the former medical group administrator at Harriman Jones, and other UMG leaders met with medical groups in the region to try to convince them to join UMG and sign with CommuniCare; the more groups that were available, the more desirable the HMO would be to employers. Hillman recalls “I was literally on the stump for Blue Cross.”

Despite their support for CommuniCare, the groups feared becoming dependent on one HMO, and were happy to sign contracts with two other new HMOs which soon approached them: PacifiCare, created in 1977 by the nonprofit Lutheran Hospital System, and Maxicare, created in 1973 by consultant Fred Wasserman and the eight physicians of the Hawthorne Medical Group. PacifiCare’s CEO was the groups’ former colleague Terry Hartshorn, who had administered the

Moore-White Medical Group; John McDonald, the Mullikin administrator, served on the first PacifiCare board of directors, while Marshall Bernes, of California Primary Physicians (now HealthCare Partners) was PacifiCare’s first medical director. To help PacifiCare get started, the UMG groups accepted a capitation rate 5% lower than they received from CommuniCare.

In Northern California, the Palo Alto, Redwood, Sunnyvale, and San Jose medical clinics had been providing prepaid professional services to Stanford University students and employees for many years through a loose organization called the Unified Medical Clinics (UMC). Blue Cross of Northern California provided hospital insurance for UMC patients on a traditional indemnity basis. When California’s Knox-Keene Act regulating HMOs passed in 1976, it required that all prepaid contracts be administered by HMOs, effectively making the UMC-Stanford contract illegal. The UMC groups were not interested in creating an HMO, which would have to be structured to meet the Knox-Keene Act’s stringent regulations. But they did want to continue their arrangement with Stanford, and they did want to find a means to compete with Kaiser. They began meeting with Blue Cross; in 1978, “after 28 contract iterations,” a new HMO, called TakeCare, emerged.<sup>2</sup>

TakeCare, PacifiCare, Maxicare, and CommuniCare all offered similar contracts to medical groups. The groups were capitated for their professional services and shared risk with the HMO for other services, such as hospital care. Typically, an HMO created an annual “hospital risk pool” for each group; any funds remaining in this pool at the end of the year were split more or less evenly between the medical group and the HMO. Responsibility for utilization management of their own services, and to varying extents for hospital and other services as well, was delegated by the HMOs to the medical groups. Figure 1, a copy of a CommuniCare document dated 4/5/76, lists the services the HMO covered, and how the risk was divided between the UMG and Blue Cross. The categories created at that time are used in California to this day, although over the years the medical groups have gradually taken on more of the risk. Initially the groups were quite concerned about accepting risk, but they were protected to a considerable degree by sharing risk with the HMOs, by reinsurance for high cost cases provided by the HMO, and by several other safeguards.<sup>3</sup>

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**Figure 1: Unified Medical Groups—CommuniCare Risk Assumption, 1976**

<u>Type of Service:</u>	<u>Risk:</u>
Professional Services	100% Medical Group
Nuclear Medicine	Shared Risk
Catastrophic Coverage (Organ Transplants and Hemodialysis)	100% CommuniCare
Hospital Services (Hospital, ECF, and Home Health)	Shared Risk
Other Services (Ambulance, Prosthetic Appliances, and Blood)	Shared Risk
Out-of-area Services	100% CommuniCare

Optional Services:

Prescribed Drugs	Shared Risk
Vision Care	100% CommuniCare
Dental Care:	100% CommuniCare

Source: "Arrangement between Unified Medical Groups and Blue Cross CommuniCare." Unified Medical Group Association Archives, dated 4/5/76.

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The creators of these HMOs—which eventually became among the largest in California and the United States—chose to focus on contracting with medical groups and to delegate utilization management to the groups. They could have contracted with individual physicians, through IPAs controlled by the HMO, with the HMO doing the utilization management.<sup>4</sup> Alternatively, they could have formed their own staff model HMOs by directly employing physicians.<sup>5</sup> Around 1980, Health Net did in fact make a limited, brief, and unsuccessful attempt to do so. But it appears that contracting with medical groups—small as most groups were at that time (many had ten or fewer physicians)—was the quickest and easiest way to get started, and that the groups were reluctant to sign contracts which placed utilization management in the hands of the HMO:<sup>6</sup>

"It was a sellers' market, with the medical groups being the sellers.

The tide didn't turn until around 1984. At that point groups were calling PacifiCare to be included, rather than PacifiCare having to go out and persuade groups to sign contracts."

—High-ranking PacifiCare Executive

"Our sales pitch to the groups was: 'You can succeed by managing yourselves.' We contrasted this with the possibility of the government stepping in to control costs."

—Terry Hartshorn, CEO, UniHealth, former CEO, PacifiCare

### **The 1980s: Medical Groups Learn to Manage Care in a Favorable Environment**

Medical groups that signed contracts accepting financial risk for HMO enrollees had to develop new capabilities if they were to succeed. They had to learn to negotiate with HMOs, manage the costs of care of their own patients, negotiate contracts with specialists and ancillary service providers outside the group, review the care of patients referred to these providers, and develop new data and accounting systems. Fortunately for the groups, it was not necessary to develop these capabilities overnight. Growth in their numbers of capitated patients was fast enough to keep them learning, but not so fast that they couldn't handle it. Meanwhile, they were to some extent buffered from the potentially adverse financial consequences of accepting risk. In the early contracts, HMOs took responsibility for many ancillary services. And premiums paid by purchasers to

HMOs during the 1970s and early 1980s exceeded indemnity insurance premiums, which made it possible for HMOs to offer the groups high capitation rates for professional services and generous parameters for the distribution of the hospital risk pool. (During the early contract years, the groups made money if they were able to reduce hospital days per thousand per year to 450 or less for non-Medicare patients.)

“It was a low risk business in those days, because of high premiums and, most important, because the groups had time—they had ten years to learn about managed care with growth that wasn’t so fast that they would choke on it. The groups had time to learn, reflect, develop a managed care culture. They also had time to realize that managed care made it possible for them to do a lot of good things for patients.”

—High-ranking HMO Executive

Without exception the five medical groups profiled in this report signed HMO contracts as a defensive measure, without much enthusiasm, and with no sense that caring for capitated patients would soon be nearly their entire business. But during the early 1980s, as new HMO enrollees flowed into their practices, and as the HMOs asked the groups to open offices in new sites, they began to realize that capitated medical care gave them both the incentive and the ability to grow in ways which they had not previously imagined. As they steadily reduced the hospital utilization of their patients, they could open new offices, using profits generated from the hospital risk pool. They could add new physicians to staff these offices with confidence that the HMOs would provide sufficient patients to keep these physicians busy. The physicians would be unlikely to leave the group to start their own practices (as often happened during the fee-for-service era), even after they developed a loyal patient base, because patients came to the physicians through HMO contracts, and the medical group held those contracts.

By the mid-1980s the groups had doubled or tripled their number of physicians and had large numbers of capitated patients (Tables 1 and 2). The groups were encountering serious operational difficulties in caring for roughly equal numbers of capitated and fee-for-service patients. Capitated care requires not only an investment in expensive utilization management systems, but also different physician compensation methods, different ratios of specialists to primary care physicians, different computer information systems, and a different culture among the group’s physicians. At some point, each of the five groups decided to develop operational systems as if all its patients were capitated.

“Our definition of managed care is capitation. We decided to begin to treat every patient as a capitated patient. The decision to commit to managed care was the single most important decision our organization has ever made.”

—David Druker, MD, President, Peninsula Coastal Region, Sutter/CHS,  
former executive director of the Palo Alto Medical Group



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**Table 1: Growth of Five California Medical Groups: Physicians**

	Number of Physicians <sup>7</sup>				
	<u>1979</u>	<u>1985</u>	<u>1990</u>	<u>1994</u>	<u>1994 % PCP<sup>8</sup></u>
Bristol Park	7	16	37	63	97%
Friendly Hills	17	55	113	147	53%
HealthCare Partners <sup>9</sup>	12	25	40	241	81%
Mullikin	30	83	99	331	59%
Palo Alto	126	145	146	162	38%

**Table 2: Growth of Five California Medical Groups: HMO Enrollees**

	Commercial Enrollees <sup>10</sup>			
	<u>1979</u>	<u>1985</u>	<u>1990</u>	<u>1994</u>
Bristol Park	500	22,458	72,912	91,877
Friendly Hills	8,000	n/a	78,620	84,650
HealthCare Partners	0	19,000	39,200	171,698
Mullikin	10,016	52,000	85,491	229,791
Palo Alto	2,000	21,971	31,112	53,940

	Medicare HMO Enrollees			
	<u>1979</u>	<u>1985</u>	<u>1990</u>	<u>1994</u>
Bristol Park	0	0	0	2,427
Friendly Hills	0	n/a	11,428	15,401
HealthCare Partners <sup>11</sup>	0	6,000	13,045	28,717
Mullikin	0	1,000	3,048	19,294
Palo Alto	0	0	0	3,155

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As the groups became more confident in their ability to manage care, they negotiated to take more and more financial risk—and a larger and larger part of the insurance premium dollar—from HMOs.

“The HMOs were willing to give the groups nearly all of the financial risk and to take their cut up front.

Al Barnett, at Friendly Hills, was the first to recognize that there really was no risk when you took an unmanaged situation and began to manage it. To take on more risk, Barnett was willing to contract

for what would have been lower rates if he hadn't been able to control utilization, but Friendly Hills actually

did better because they were able to allocate the risk dollars themselves and to obtain the full financial benefit from managing care.”

—James Hillman, Executive Director, Unified Medical Group Association

By taking more risk, medical groups could have a higher cash flow, develop utilization management expertise in more areas, and have more negotiating power with hospitals, with specialists outside the group, and with ancillary providers like laboratories and home health services. The groups could also keep any profits they generated, rather than sharing them with HMOs. As Noah Rosenberg, JD, legal advisor to many California medical groups and IPAs, pointed out at the 1996 UMGA annual meeting, “The goal for physicians in managed care is to get as much risk as possible and to be in charge of managing the risk themselves.”

### **The 1990s: Increasing Competition, the Drive to Grow, and the Sale of the Groups**

During the early 1990s, relationships between California medical groups and HMOs, and among medical groups, became much more competitive. The state's major HMOs became publicly traded corporations, responsible for showing favorable financial results to Wall Street every three months. In a market that had become increasingly saturated, they struggled for increased market share by undercutting each other's premiums. Pressure on premiums also resulted from a severe, prolonged recession in Southern California and from the California Public Employees Retirement System (CALPERS) and the Pacific Business Group on Health (PBGH), a purchasing coalition of large employers. These powerful purchasers succeeded in winning premium decreases from HMOs (PBGH, for example, gained reductions averaging 7% for 1995 and 4% for 1996). They also began to demand data on quality and patient satisfaction from the HMOs, bluntly making it clear that they expected HMOs to do more for less money.

The HMOs, in turn, demanded that the medical groups also do more for less. This provoked conflict, but was not the only cause of HMO-medical group discord of the 1990s. The groups also clashed with HMOs over “full risk contracting” and over responsibility for utilization management. At stake was a fundamental question: who would occupy the central position in the health care system?

California's HMOs all had essentially the same physician and hospital networks, and worried

that they were becoming mere interchangeable commodities, with employers simply contracting with the lowest price HMO.

“With increasing purchaser sophistication on the one side, and increasing provider sophistication on the other side, the market could threaten to remove the place of the middleman of questionable value—the HMO. Purchasers are trying to learn more about providers.”

—High-ranking California HMO Executive

It became apparent to both medical groups and HMOs that competitive advantage would be won by those organizations that could “add value” by being better than others at managing the cost and, as measurements became available, the quality of care. HMOs began to reconsider the advisability of allowing medical groups to do nearly all utilization management and to bear nearly all of the financial risk of caring for patients. As one medical director at a large California HMO pointed out:

When excess capacity is gone, hospitals and physicians could have more power. Then the question will be: Where is the managed care expertise? Who knows how to manage care? Will it be the HMOs or the medical groups and IPAs?

HMOs began to hire more medical directors and to seek ways to use their superior data systems to become more involved in utilization management. They also supported the California Department of Corporations’ (DOC) inquiry into whether medical groups should be permitted to take “full risk” for HMO patients.

California’s Knox-Keene law made it difficult for provider organizations—medical groups or hospitals—to obtain full risk in a straightforward manner. The DOC interpreted the law to mean that providers could take risk only for those services for which they were licensed. Physicians could take risk for professional services, and hospitals for hospital services, but neither could accept risk for the services provided by the other. During the late 1980s and early 1990s, however, large California medical groups were able to gain a near equivalent to full-risk contracts by a variety of subtle contractual arrangements with HMOs, or by buying their own hospital and using that hospital to subcontract with other hospitals. The DOC had ignored these arrangements, but decided to act as managed care became more of a media issue and as medical groups grew larger.<sup>12</sup>

After several years of controversy, the DOC created a new form of license, called a “limited Knox-Keene license,” whereby provider organizations are permitted to sign full risk contracts with HMOs. Unlike HMOs, however, organizations with limited Knox-Keene licenses may not contract directly with purchasers to provide prepaid medical care; they must contract with HMOs, which in turn contract with purchasers. They must also comply with a number of financial requirements mandated by the DOC.<sup>13</sup>

#### *Competition from Independent Practice Associations*

California’s IPAs obtain HMO contracts for the many physicians—typically in solo or small group practices—who contract with the IPAs to care for the HMOs’ patients. IPAs are attractive to

many physicians because they provide an opportunity for them to remain in their own practices; they are attractive to many patients and employers because they offer a broader choice of physicians than medical groups. Many IPAs which appeared during the 1980s were created by specialists, supported by their hospital, as a method for retaining control of the local medical care market. They were loosely run organizations that made little attempt to manage the costs or quality of care. But during the 1990s, some IPAs began to show an increased ability to manage care. This new ability, combined with a number of advantages of IPAs over large medical groups, made them increasingly formidable competitors (Robinson and Casalino, 1996).

*The Drive to Grow*

During the early 1990s California's large medical groups found that neither their revenue per HMO patient nor their numbers of new HMO patients were increasing as they had during the previous decade. Competition among HMOs for market share and pressure from large purchasers reduced the premium income available to distribute to the groups, while recession, saturation of the HMO market, and competition from IPAs reduced the number of new patients available. Yet now more than ever there were incentives for groups to grow, and to grow as quickly as possible. Larger groups would have more negotiating strength with HMOs. They could spread the increased financial risk they were taking over larger numbers of patients. They could gain economies of scale in administration and in the data systems necessary to manage care and to produce quality data. And the groups began to realize that a large medical group might bring a very high price if sold—and the larger, the better.

The Mullikin medical group was the first to decide that the incremental growth strategy pursued by the groups during the 1980s—hiring new physicians and opening small new offices with HMOs supplying patients—was no longer enough. In 1990, Mullikin started its own IPA, and, beginning in 1991, broke with a convention tacitly shared by the groups—not to invade each other's territory—and moved aggressively to acquire groups throughout the Los Angeles region:

**Table 3: Mullikin Medical Center Medical Group Acquisitions, 1991-1992**

<u>Medical Group</u>	<u># of Physicians</u>	<u># of HMO Patients</u>
<u>1991</u>		
Westminster Medical Group	29	23,000
<u>1992</u>		
Burbank Medical Clinic	21	24,000
Naples Medical Group	7	7,000
Moore-White Medical Group	19	10,000
Roberts Medical Group	15	16,000
Hawthorne Medical Group	80	88,000

California Primary Physicians countered by merging with the large Huntington and Bay Shores medical groups to form HealthCare Partners, while Bristol Park, Friendly Hills, and the Palo Alto Medical Clinic continued to focus on incremental growth in their own areas. But by 1996, all the groups except HealthCare Partners had sold their assets to a much larger, capital-rich organization (Table 4).<sup>14</sup> The groups simply could not generate enough capital on their own to grow rapidly and believed that it would be safer to be part of a large organization during the increasingly competitive, turbulent and unpredictable evolution of managed care. Furthermore, by selling, the groups' physicians and senior executives would receive large sums of money for their share in the group; this was an offer it was difficult to refuse, given the uncertainty of the future.<sup>15</sup>

**Table 4: Affiliation of Thirteen Major California Medical Groups: 1992-1996**

<u>Group</u>	<u>1992 Status/Affiliation</u>	<u>1996 Status/Affiliation</u>	<u>Affiliate Type</u>	<u>Relationship</u>
Bristol Park system foundation	Independent	St. Joseph of Orange		hospital
Friendly Hills	Independent	MedPartners	PPM	MSO
HealthCare Partners	Independent	Independent	Independent	-
Mullikin Independent	MedPartners	PPM	MSO	
Palo Alto	Palo Alto Med. Found.	Sutter Health	hospital system	foundation
Beaver	Independent	Unihealth	hospital system	MSO
Facey	Independent	Unihealth	hospital system	foundation
Harriman-Jones	Independent	Unihealth	hospital system	MSO
MedClinic	Cath. Hlthcr. West	Cath. Hlthcr. West	hospital system	foundation
Pacific Physicians	PPS PPM	MedPartners	PPM	MSO
Rees-Stealy	Sharp Hospital	Sharp Hospital	hospital system	foundation
San Jose	Independent	Unihealth	hospital system	MSO
Scripps	Scripps Institute Fndtn.	Independent	Independent	-

## **FIVE MEDICAL GROUPS**

### **Mullikin Medical Center**

Mullikin Medical Center (MMC) was one of the first groups to understand the incentive and the opportunity for growth brought by capitated contracts. It was the first to form a successful IPA, the first, and one of the only groups, to buy the practices of many other groups, and the first to move into other regions of California and other states. In 1994, Mullikin had 331 physicians,

249,000 capitated patients, and \$366 million in revenues, of which 96% came from HMO contracts.

Dr. Walter Mullikin, a general surgeon, arrived in Artesia, a rural area southeast of Los Angeles, in 1957. During the following twenty years, as Artesia was changing from a farming community to a populous suburb, Dr. Mullikin built and expanded Pioneer Hospital (a 99-bed, acute care hospital) and gradually hired physicians to work for him. In 1979 he sold the practice to twenty-one of the thirty physicians in the group. He and John McDonald, who had been Mullikin's administrator since 1966, continued in their leadership roles.

By 1983, a majority of Mullikin's patients were capitated (Table 5) and the group was positioning itself as a managed care veteran:

We anticipated long ago that health costs could be considerably reduced through prepaid medicine...  
 [our] physicians began their relationship with HMOs long before other health care professionals realized  
 the way of the future...our utilization plan has been used as a model for other medical groups and health maintenance organizations...our own physicians, through their active participation in utilization control,  
 have helped to contain the cost of health care to our own patients.

—Mullikin Medical Center, *Annual Report to Shareholders*, 1983

By 1990, Mullikin had 100 physicians and 90,000 capitated patients. The group financed its growth using profits from the hospital risk pool, bank loans, loans from the Cerritos Investment Group (the real estate partnership, made up of a number of the group's physicians and executives, which owned the group's clinics), and by retaining some earnings rather than paying all income out to the physicians. But Mullikin's leadership became convinced that even faster growth was necessary. In 1992, MMC executed six mergers with Los Angeles area medical groups, adding 156 physicians, 145,000 capitated patients, and \$98 million in gross revenues (Table 3).<sup>16</sup> These "mergers" were in fact acquisitions, paid for by Mullikin with a combination of cash, notes payable, and Mullikin stock given to physicians in the acquired groups.<sup>17</sup> The ability to exchange MMC stock for the medical groups' assets greatly reduced MMC's immediate need for cash and/or bank loans.<sup>18</sup> MMC was also aided by the fact that mergers/acquisitions between medical groups were legally much simpler than transactions (for example, the formation of a foundation) in which hospitals in effect "purchased" medical groups. MMC was therefore able to complete its mergers in months, rather than years, and to save millions of dollars in legal and consulting expenses. The groups sold to Mullikin because they wanted to be part of a larger organization and because they were in varying degrees of financial distress, due to the recession and to the fact that many had large, unfunded obligations to buy out the ownership shares of retiring partners.

**Table 5: Growth in Mullikin Medical Center Prepaid Care<sup>19</sup>**

<u>Year</u>	<u>Fee-for-Service</u>	<u>Annual Visits</u> <u>Prepaid</u>
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	<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent</u>	
1977	60,000		66%	8,000	8% <sup>20</sup>
1979	61,000		63%	11,000	11%
1982	70,000		50%	50,000	36%
1985	112,000	33%	200,000		59%
1990	113,000	21%	401,566		76%
1994	105,000	10%	944,000		90%

Mullikin was one of the first medical groups in California to start an IPA and the only group whose IPA grew to a significant size. The Mullikin IPA (MIPA) grew mainly by acquiring small, troubled IPAs and bringing them Mullikin's HMO contracts and Mullikin's administrative discipline and utilization management experience. By late 1994 MIPA contracted with nearly 3,000 physicians and had 60,000 enrollees statewide. MIPA helped Mullikin to enter new areas and to expand enrollment more quickly and inexpensively than was possible by acquiring medical groups.<sup>21</sup> By using a two-pronged strategy of acquiring medical groups and an IPA in a given area, Mullikin hoped to meet market demands for both kinds of product, to increase its negotiating strength with HMOs and hospitals, to achieve managerial economies of scale, and perhaps to find physicians within the IPA who might eventually become valuable members of the Mullikin organization.

Mullikin's ownership of Pioneer Hospital was doubly useful: the hospital was cooperative with the group's utilization management efforts, and it provided a way for the group to obtain full risk for hospital services by negotiating contracts in which HMOs, through Pioneer, gave Mullikin the entire percentage of the premium dollar allocated for hospital services (Mullikin then subcontracted with other hospitals in areas where the group had patients). Between 1984 and 1990, while sharing risk pool profits with HMOs (and between Pioneer and the medical group), the group received settlements averaging over a million dollars a year from the hospital risk pools. At that point MMC and Pioneer started receiving full risk for most of MMC's HMO patients, and the amount MMC received from the "hospital pool" increased far more rapidly than its enrollment: MMC received \$4.8 million in 1991, \$7 million in 1992, and \$15.6 million in 1993.<sup>22</sup> At the end of 1994, Mullikin had full risk contracts for 81% of its patients.<sup>23</sup>

In 1994, Mullikin moved into Northern California by acquiring four medical groups and 15,000 capitated patients, as well as several IPAs, in the San Francisco area. In 1995, Mullikin moved out of state for the first time, acquiring two medical groups in Oregon.<sup>24</sup> At this point Mullikin was short of capital, its management resources were stretched thin by its extraordinarily rapid growth, and its senior management was ready to retire. Mullikin agreed to be acquired for \$360 million by MedPartners, a publicly traded physician practice management company (PPM), based in Birmingham, Alabama.

### **Friendly Hills Healthcare Network**

The Friendly Hills Medical Group, created in 1968 by Dr. Albert Barnett and two other general practitioners in the Los Angeles suburb of La Habra, is notable for its tight physician-hospital integration, for selling its assets to a foundation created by an academic medical center (Loma Linda), and for withdrawing from the arrangement with Loma Linda to become part of Caremark, a

PPM. In 1994 Friendly Hills had 147 physicians, 100,000 capitated patients, and \$175 million in revenues, of which 90% came from HMO contracts.

In 1976, Friendly Hills' dozen physicians disagreed over whether to sign the group's first HMO contract (with Blue Cross CommuniCare); they finally agreed, but with the caveat that HMO patients would not become more than 10% of their practice. But their thinking changed over the next few years, as large numbers of capitated patients poured into the practice (the few other groups in the area had refused to contract with HMOs). Until Mullikin's spurt of acquisitions in the early 1990s, Friendly Hills' growth in numbers of physicians and capitated patients had paralleled Mullikin's (Tables 1 and 2), but Friendly Hills limited its operations to a few large offices in a narrow geographic area surrounding the Friendly Hills Regional Medical Center, a 274-bed community hospital which the group had purchased in 1988.<sup>25</sup> Because Friendly Hills owned the hospital, and all its physicians and patients were located near the hospital, the group was able to focus on integrating outpatient and inpatient administrative and clinical systems.<sup>26</sup> Horizontal growth, achieved by acquiring practices in dispersed geographic areas, would prevent utilization of Friendly Hills' highly integrated hospital systems. (Barnett, 1993)

During the early 1990s, Friendly Hills, like other medical groups, faced an increasingly competitive situation, and also had a serious financial problem: the group had no funds to buy out the many senior partners nearing retirement. The group chose to sell their hospital and the assets of their practice for \$125 million to a newly-formed healthcare foundation controlled by Loma Linda University Medical Center. The Internal Revenue Service reviewed the proposed arrangement and, in a nationally publicized decision, issued guidelines for the creation of medical foundations. The Friendly Hills HealthCare Foundation began operations in January, 1993, with the Foundation contracting with HMOs to provide both hospital and physician services, and the Friendly Hills medical partnership contracting with the Foundation to provide medical services.<sup>27</sup>

Within little more than a year, the Friendly Hills physicians, dissatisfied with what they perceived as the slow pace of executive decision-making in the Foundation and with the difficulty of coordinating medical care with the specialists at Loma Linda's medical center, sought a white knight to buy them out of the situation. They chose Caremark, a national physician management company. Caremark bought the medical care assets of the Foundation, including the hospital and the medical group offices, for \$156 million. Though a Loma Linda spokesman accused Friendly Hills of "simply taking a better deal when it came along" (*Health System Leader*, September, 1994, p. 3), the physicians, who had already sold their assets, received only a small amount of Caremark stock as part of the deal. Two years later, in 1996, Caremark was acquired by MedPartners, and the Friendly Hills physicians found themselves members of the same organization as their former competitors from Mullikin.

### **HealthCare Partners Medical Group**

HealthCare Partners Medical Group (HCP) is the only group of the five profiled in this report to have remained independent.<sup>28</sup> In 1994 HCP had 241 physicians, 201,000 capitated patients, and \$209 million in revenues, of which 95% came from HMO contracts. HealthCare Partners was created between 1992 and 1994, when California Primary Physicians (CPP) and the Huntington



Medical Group joined forces, then merged with the Bay Shores Medical Group. These were mergers between groups of roughly equal size; the groups merged because of the new competitive pressures and in response to Mullikin's dramatic wave of acquisitions.

CPP was created in 1975 by seven emergency room physicians at California Hospital, an inner city Los Angeles institution. The group initially refused to contract with HMOs, but began to do so in 1981, and experienced rapid growth. Soon HMOs were inviting CPP to open offices in other areas, but the physicians usually declined. Robert Margolis, MD, CEO and Managing Partner, Healthcare Partners Medical Group noted that "the fact that we lacked competition was a two-edged sword. It was nice, but it meant we didn't feel much pressure to grow rapidly."

The Bay Shores Medical Group, based in the middle class suburb of Torrance, was created by three family physicians in 1956. By 1976, when Bay Shores signed its first HMO contract (with Maxicare), the group had twenty physicians, of whom half were primary care. The decision to work with HMOs remained controversial; between 1980 and 1982 nearly half the group's physicians left, and those who remained decided to make a commitment to prepaid care. Their position was strengthened when Bay Shores' HMO patient population doubled between 1982 and 1983, from 6,200 to 12,300. By 1989, Bay Shores had 63,000 capitated patients.

The Huntington Medical Group, founded in 1940, was still just a handful of internists in 1980, when Huntington's physicians joined with a few other internists and pediatricians and an obstetrician to form the first multi-specialty group in Pasadena and to sign a Health Net contract.

During the past few years, while Mullikin stretched its organization financially and administratively in order to grow as rapidly as possible, HCP chose to move more slowly, avoiding debt and investments from outsiders, and trying to be sure that its ability to manage the organization efficiently kept pace with its growth. HCP has been able to keep large sums of money in reserve, because, unlike other groups, it retains some revenue each year, rather than paying out as much as possible to its physicians. Dr. Robert Margolis, one of the founders of California Primary Physicians and the CEO and Managing Partner of HealthCare Partners, has consistently argued that:

"Medicine is a local, not even a regional, business. Physicians organized in integrated groups could control medical care, but they are being picked off by hospitals, health plans, and venture capitalists. Physicians are self-driven individualists. Nonproductive physicians who are employed by a hospital are worse for that hospital than affiliated physicians who are happy."

Whether HealthCare Partners will continue to adhere to its course, given the ever larger HMOs and physician management companies with which it must compete, and the large, immediate financial gain which its members could realize by selling, remains to be seen.

### **Bristol Park Medical Group**

Bristol Park is the only large, exclusively primary care physician medical group in California. By 1994, Bristol Park had 63 physicians, 94,000 capitated patients, and \$66 million in revenue, of which 91% came from HMO contracts.

In 1978, when Bristol Park signed its first HMO contract, the group consisted of seven primary care physicians; four more than when it was created in 1959. The physicians' attitude toward HMOs ranged from lack of interest to outright hostility, but they were persuaded by John Hammet, their administrator, to sign with CommuniCare, while agreeing to limit their practice to less than 5% HMO patients, and to withdraw from the contract if they lost as much as \$40,000. Bristol Park's HMO population grew more rapidly and was more profitable than the physicians had expected. The group opened offices in Irvine in 1981, in Santa Ana in 1982, and in Fountain Valley and Mission Viejo in 1984. With the success of each new office, Bristol Park would open another, generally following the track of the 405 Freeway. The growth was encouraged by the HMOs, which needed physicians in more locations in order to sign contracts with employers who had employees in those locations.

In 1987, Bristol Park paid \$1.5 million to purchase a 50% share in Coastal Communities Hospital (CCH), a 160-bed facility located in Santa Ana. The primary objective of the purchase was to obtain full risk contracts from HMOs. By 1994, six HMOs representing 75% of Bristol Park's capitated business had agreed to full risk contracts for the patients at CCH. The HMOs kept roughly 20% of each premium dollar; paid roughly 40% to Bristol Park for professional services; and put 40% into a pool for hospital services, including skilled nursing facility and home health. But the overall impact of the purchase on Bristol Park was not large. Patients from outside Santa Ana did not want to travel to CCH, so the number of Bristol Park patients hospitalized there was small. Unlike Mullikin, Bristol Park did not use its ownership of a hospital to sub-capitate other hospitals, and thus did not obtain the benefits of having full risk for all its HMO patients. (In 1994 Bristol Park patients accounted for only about 20% of the hospital's census.)

Bristol Park's decision to be an all-primary care group emerged gradually, but by the 1990s the group had elaborated a set of arguments for its position:

1. *Choice of specialists:* In 1994, Bristol Park had contracts with nearly 1000 specialist physicians. By "buying" rather than "making" specialty services, Bristol Park could offer a wider choice of specialists, including expanded geographic range and ethnic diversity, than even the largest multi-specialty group.
2. *Flexibility:* to adjust its specialist mix in accordance with market demands.
3. *Incentives for specialist performance:* Multi-specialty groups can use incentives to induce better performance from specialists, but these incentives typically account for only a small percentage of the physicians' income. More drastic measures—like firing a physician—are rarely used, and can be very difficult once the physician has become a partner in the group. In sharp contrast, Bristol Park could easily stop contracting with or stop referring patients to a specialist whose technical skills, cooperation with utilization and quality management, and/or relations with patients or referring physicians were considered unsatisfactory.
4. *"Recalibration" of physician incomes:*<sup>29</sup> Bristol Park has been able to negotiate payment rates with specialists which are considerably lower than the "usual, customary, and reasonable" fees to which the specialists had become accustomed. Given the surplus of specialists in Orange

County, most will discount their rates in order to obtain a higher volume of patients.

5. *Cohesive governance:* Primary care physician ownership has meant that Bristol Park has avoided the power struggles between primary care physicians and specialists often found in multi-specialty groups, in which PCPs may be treated like second class citizens, and in which they have to plead with specialists for a larger share of the group's income. The lack of specialists at Bristol Park's Patient Care Committee meetings is a drawback, however, since it limits the range of expertise available in discussing patients' cases.

During the 1990s, Bristol Park's strategy had three core elements: continued growth in Orange County ("depth rather than geographic breadth," as Patrick Kapsner described it), physician ownership, and primary care physicians as the integrators of care.

"If PCPs have the knowledge to manage and coordinate care, then they, not a third party, should have the risk and reward of managing a significant share of the capitation dollar. As owners of the group, they have the incentive to do that job and do it well."

—Patrick Kapsner, *Health System Leader*, May 1994

Though Bristol Park's physicians and executives valued their independence, during the 1990s they, like other groups, felt an increasing pressure to obtain capital to develop better data systems in order to manage care and demonstrate quality. They also felt a strain on their incomes due to the virtual halt in the growth of HMO premiums and patients in their area. The group had to consider whether it was likely that it would remain independent forever. If not, when would be the best time to sell? Most felt that the time was now. Bristol Park had many suitors, but it chose the nonprofit, hospital-based St. Joseph Health System. In mid-1996, the Heritage Foundation, created by St. Joseph, purchased the assets of Bristol Park. The medical group now contracts with the Foundation to provide medical services.

### **Palo Alto Medical Clinic**

The Palo Alto Medical Clinic (PAMC) differs from the other groups profiled in this report in that it was very large at the time it began contracting with HMOs (126 physicians in 1979), it had an established reputation for specialist care, it had a relatively exclusive relationship with a university hospital (Stanford Hospital), and it had experienced comparatively slow growth in the numbers of physicians and capitated patients it had added during the previous two decades. In 1996, the PAMC had 162 physicians, 57,000 capitated patients, and \$91 million in revenues, of which 45% came from HMOs.

PAMC was created in the 1920s; during the following decades the group aimed to become a Mayo Clinic of the west. As described in Chapter 1, the group had been giving prepaid care to Stanford University students and employees for two decades before it worked with Blue Cross and other medical groups to create TakeCare. PAMC maintained a virtually exclusive contracting relationship with TakeCare until 1990, at which point the group began to seek contracts with other

HMOs. During the 1980s, TakeCare had worked closely with PAMC (Dr. Robert Jamplis, a physician leader of the group, served as chairman of the board of TakeCare in 1986; PAMC also owned a substantial amount of TakeCare stock, which it had been able to buy at favorable prices) and paid the group premium rates to maintain exclusivity, but eventually PAMC needed access to more capitated patients than any single HMO could supply.

During the late 1980s, the clinic physicians decided to make a strong commitment to capitated care, but they were very focused on their single-site, multi-specialty practice and gave little effort to expanding into nearby areas. As of 1996, PAMC had added only two small satellite clinics.

PAMC's high proportion of specialists (by 1996, the group was still only 40% primary care) and its close relationship with the high-cost Stanford University Hospital could be significant obstacles to succeeding in capitated care, but the group was able to benefit from the high capitation rates it was able to negotiate with HMOs.

“In the north, you have trouble making it without certain medical groups. If you don't, for example, have the Palo Alto Medical Clinic, you're not going to get into the Silicon Valley employer market.”

—Judd Jessop, former CEO, TakeCare

In 1987 PAMC sold its assets, including its medical building, to the Palo Alto Medical Foundation for \$35 million—a low price by today's standards. The sale gave the physicians cash to fund their obligations to retiring partners and made it possible for new physicians to buy into the partnership for only \$10,000; previously the price had been many times that amount. The Foundation itself was independent, though heavily influenced by PAMC. By the early 1990s, the group's medical building was becoming cramped and outdated, and the organization needed better information systems, even after spending \$3.5 million for a computer system in 1991. The group decided to seek capital for a new building and new information systems, and also possibly to open or purchase primary care clinics nearby. Furthermore, some of the physicians believed that PAMC would need to be part of a regional or statewide organization if it were to continue to compete successfully.

After talks with several organizations, including Stanford, Caremark, and the Sutter Health System,<sup>30</sup> PAMC chose Sutter. It “seemed like a perfect partner—a nonprofit organization which had capital, a northern California network, and the willingness to give physicians local autonomy,” according to Robert Jamplis, MD, President and CEO, Palo Alto Medical Foundation, and former Executive Director of the Palo Alto Medical Group. In 1993, Sutter Health, a 501(c)(3) California nonprofit corporation, pledged to give \$50 million to the Palo Alto Medical Foundation, also a 501(c)(3), in return for three seats on the board and for legal status as the “sole corporate member” of the Foundation.<sup>31</sup> As it did before the affiliation with Sutter, the PAMC physician partnership continues to contract with the Palo Alto Medical Foundation to provide professional services.

## **ORGANIZING TO MANAGE CARE**

### **Ownership**

Who should own medical practices? California physicians have always believed that they should own their own practices; the state's corporate practice of medicine law enshrined this belief into the legal code. Each of the five groups profiled in this report made it relatively easy for their physicians to become owners. They believed that physician-owners would work harder, use resources more wisely, and cooperate with other physicians for the good of the group. According to Dr. Carlos Sobral, a Friendly Hills physician, during the early 1980s the group sometimes had to borrow money to pay its physicians, but there was little grumbling. "We trusted our leadership. We were very much of one mind; we all had a similar stake in how the business was doing. "

As the groups grew, and as HMOs and hospitals in California found ways around the corporate practice of medicine law,<sup>32</sup> many of the leaders of the groups argued for the superiority of this "physician equity" model. Those groups that sold their assets to medical foundations or to management service organizations operated by nonprofit hospital systems had to give up the model. Groups that sold to physician practice management companies (PPMs) sometimes claimed that they were still physician equity organizations, because the group's physicians received stock in the PPM.

There may be a significant difference, however, between being an owner of a group of fifty to one hundred physicians who are working together, and being a small stockholder in a company employing thousands of physicians around the country. The point of the physician equity model was that physicians cared how their organization did, and would feel that they could have an impact on the organization's success or failure. This attitude may be diluted for physicians working in PPMs.

Nevertheless, there are compelling reasons why medical groups sell their assets. Small groups feel that they cannot continue to compete successfully on their own. Large groups have the same belief, and, in addition, have become so valuable that it is economically irrational for a physician to have all his or her equity tied up in a single organization and its uncertain future. Selling the practice gives the physicians liquidity, and makes it possible for each to spread his or her equity in the practice over a broad range of investments.

## **Governance**

"You could look at a group and could predict, by looking at the strength of both the lay and the medical leadership, how well the group would do."

—Alan Hoops, CEO, PacifiCare

Small California medical groups have traditionally been extremely democratic—often operating by consensus. They have had trouble making decisions, and trouble implementing the decisions when made. During the fee-for-service era, a discontented physician could easily leave the group and take his or her loyal patients along. But the administrative demands on groups were small, and inefficient operations could be highly profitable as long as they generated large amounts of fee-for-service billing.

Prepaid medical care makes efficient operation both more important and more possible. Tighter administrative controls are more possible because it is harder for physicians to leave, since their group holds the HMO contracts. Tighter control is more important because prepayment means that a medical group must manage care within a budget, and, as the system has evolved, that it pro-

duces quality data. Group managers—physicians and lay administrators—have had to make decisions that, while likely to be good for the organization in the long run, were highly unpopular in the short term. Ferial Bahremand, VP for Network Development at Blue Cross of California recalls that “Groups that failed did so because the doctors would not let the managers do their jobs. If the managers did do their jobs, the doctors would fire them.” One way or another, the groups had to restrict physicians’ current income to fund expansion. They had to develop standardized operational and clinical processes. They had to create utilization review programs. They had to change their methods of compensating physicians to create incentives compatible with the cost and quality demands of managed care.

The five groups in this report varied in the degree to which they were democratic. Mullikin was always been very explicit in its view that a large medical group cannot be a democracy; its board has always selected its own members. The other four groups all voted for their boards, though in some cases senior partners had more ownership and more votes.<sup>33</sup> Yet all five groups had extremely stable leadership during the quarter century of their involvement with managed care (Figure 2). Generally speaking, the groups have had only one or two chief physician leaders, and two or three chief lay executives, during that extended period of time. It appears that the personal charisma of these leaders, the fact that they have been careful to communicate with their partners and have been responsive to the pressure of these peers, and the fact that most of the time the groups did well, have been enough for the leaders to retain the support needed to govern effectively. ~~Each group also benefited from the extensive involvement of many physicians in the work of the~~ group’s committees.

It remains to be seen whether large organizations that purchase medical groups can maintain this process of strong yet responsive leadership as well as physician participation in running the organization.

**Figure 2: Medical Group Governance**

	<u>MD Chief Execs.</u> <u>1979-1994</u>	<u>Lay Chief Execs.</u> <u>1979-1994</u>	<u>%with 3</u> <u>or more terms</u>	<u>% turnover</u> <sup>34</sup>	<u>FP/Specialist</u> <u>%(1994 board)</u>
Bristol Park	1	2	16%	38%	100%
Friendly Hills	2	3	?	?	67%
<del>Healthcare Partners</del>	<del>2</del> <sup>35</sup>	<del>3</del> <sup>36</sup>	<del>60%</del> <sup>37</sup>	<del>?</del>	<del>20%</del>
Mullikin	1	1	14%	26%	40%
Palo Alto	3	3	7%	43%	29%

Source: medical group annual reports, newsletters, and personal communications. Complete data for Friendly Hills board members were not available.

### Relationships with Specialists

Should a medical group include specialists or contract out for specialty services? With the coming of capitation, the preeminent position of specialist physicians was abruptly reversed. They ceased to be the major revenue generators for medical groups, and instead became the groups' major cost centers, not only through the services they provided, but also through the ancillary testing and treatment which they often ordered.

Given the surplus of specialist physicians in California, there are two reasons why it might be cheaper for a medical group to contract with specialists rather than to include them in the group. First, contracting gives the group flexibility in adjusting to changes in the size and composition of its capitated patient population by adjusting its number and mix of specialists. Second, groups that include specialists typically pay them at market rates, whereas specialists outside the group, for whom the group's patients represent incremental business, may be willing to contract to see patients for relatively low rates.

Nevertheless, four of the five medical groups in this report—and all major medical groups in California except Bristol Park—are multi-specialty groups (Table 1), partly by choice, and partly because of the historical processes by which they grew. Early on, the groups included specialists because of the prestige they added and the fee-for-service revenue they generated. They also believed that having multiple specialties practicing together could lead to higher quality care, as physicians learned from each other. During the 1990s, as the groups grew by acquiring other groups, they acquired specialist members of those groups in the process, whether or not they wanted them.

Even as they were acquiring other groups, however, Friendly Hills, HealthCare Partners, Mullikin, and the Palo Alto Medical Clinic were all working to increase their numbers of primary care physicians while stabilizing or even reducing their numbers of specialists. Bristol Park and some IPAs were demonstrating the advantages of contracting with specialists rather than employing them: lower payment rates to specialists, the ability to offer a greater number of specialists, the ability to easily adjust the number and mix of specialists, and the ability to give strong performance incentives to contracted physicians.

As managed care evolves, the balance of advantages and disadvantages in making versus buying specialist care may change in favor of multi-specialty groups. (Parallel arguments can be made for the advantages of medical groups versus IPAs.) In the long run, as the surplus of specialists decreases, it will no longer be possible to contract more cheaply for specialty care. More immediately, purchaser demands for quality data will give an advantage to groups that can provide this data. It is possible, though by no means certain, that multi-specialty groups will be better able to provide data than groups which contract for specialty care. Finally, if physicians from different specialties practicing together actually does lead to higher quality care—and if this quality can be measured—multi-specialty medical groups might have an advantage.

### **The Rise and Decline of the Primary Care Physician?**

By giving family practitioners, general internists, and pediatricians a central role as gatekeepers, managed care increased public awareness of primary care and increased the income and

power of primary care physicians. But these physicians may soon find that their position in managed care is not as secure as it may have seemed during the past decade. They have benefited from the realization by executives of managed care organizations that though primary care physicians can be paid less than specialists, they can provide comparable quality of care for many medical conditions, and can be used as gatekeepers to limit access to more expensive care. This same reasoning can and is beginning to be applied to non-physician providers such as nurse practitioners and physician assistants. All five groups profiled in this report have hired increasing numbers of these non-physician providers in recent years.

The “gatekeeper” role is a creation of managed care that temporarily increased the importance of primary care physicians; it is, however, thoroughly disliked by patients, and will become less necessary as utilization management techniques evolve. As “gatekeepers,” primary care physicians are vulnerable to a diminution of their role at both ends of the clinical spectrum: by specialists acting as primary providers for patients with severe chronic illnesses, and by nurse practitioners and physician assistants handling routine clinical care. Primary care physicians might be wise to develop and demonstrate their ability to work as coordinators: “conductors” of care (Kapsner, 1994).

## **Relationships with Hospitals**

Should physician practices and hospitals be owned within one vertically integrated organization? As managed care has evolved, many hospital administrators, academic researchers, and medical reformers have tended to assume that such vertically integrated hospital-physician organizations are both desirable and inevitable. Medical groups were small, undercapitalized, and run by amateurs, whereas hospitals had capital and professional managers. Integrating medical groups into hospitals would, it has been hoped, result in decreased costs, increased quality, and administrative control of unruly physicians.

During the 1980s and early 1990s, however, few such organizations appeared in California. The state’s capitated medical groups were supporting their growth using profits from HMO-created hospital risk pools—profits in which the hospitals did not share. Most hospitals were slow to realize that they might be better off sharing in the financial risk of medical care by being capitated rather than insisting on being paid per diem or by discounted fee-for-service rates. California’s large surplus of hospital beds made it possible for medical groups and HMOs to negotiate contracts for hospital services at favorable rates.

In the 1980s, the medical groups profiled in this report, like other large California medical groups, could and sometimes did change the hospitals they used in order to obtain lower rates. But during the 1990s, with hospital utilization already decreased, and with increasing competition over both costs and quality, the groups began to seek cooperative, long-term relationships with hospitals. Medical groups believe that they have been responsible for most of the innovations in utilization management of hospitalized patients to date, but to move further they need hospitals to maintain adequate staffing levels, to make ancillary services available on a timely basis, to provide cooperative hospital discharge planning nurses, and to assist with collection of cost and quality data.

Many consultants believe that...managed care groups should shop for the



lowest [hospital] per diem or case rate that is available in their geographic area. However, many groups...have come to realize the error in this assumption after years of waiting for their first hospital shared risk check. Unless the hospital can generate clear efficiencies of operation, low per diem rates...will be a temporary illusion. Physician groups that allow themselves to be 'bought' by unrealistically low per diem rates will often find themselves utilizing a financially and operationally weak institution. This weakness frequently will be reflected in the reduced number and quality of patient care services as well as an inability to efficiently control inpatient costs. (Barnett, 1993b)

The groups believed that they had four options for working more closely with hospitals. A medical group could buy hospitals, could negotiate long-term, risk-sharing contracts with hospitals, could be bought by a hospital, or could help create a joint physician-hospital organization (PHO), as is becoming increasingly common elsewhere in the United States. (In a PHO, physicians and a hospital typically create a new organization that is jointly owned.)

Bristol Park made comparatively little use of the hospital in which it shared ownership, but Mullikin used its Pioneer Hospital extensively, both for patient care and as a way to gain full risk contracts, and Friendly Hills placed great emphasis on its ability to integrate care at its hospital, around which nearly all the group's physicians were clustered. Although hospital ownership helped these groups to become relatively stable, it was not a viable strategy for further growth. The groups could not afford to purchase prestigious hospitals, nor to purchase hospitals in all the geographic areas into which they wanted to expand. Nor, as Dr. Margolis of HealthCare Partners has argued, is it clear that administering hospitals is or should be a core competency of a medical group, nor that "making" rather than "buying" hospital care is cost-effective when a surplus of hospital beds still exists. While Friendly Hills physician leaders extolled the benefits of owning a hospital, leaders of other groups argued that properly structured contracts might work as well or better than ownership in creating physician-hospital cooperation and integrating care management.<sup>38</sup>

During the 1990s, California hospitals were eager to be capitated, but medical groups have resisted separate capitation for hospitals because they have been reluctant to share savings that they believe are largely physician-generated. Though a capitated hospital is more likely to be cooperative in managing care, the medical groups believe that physicians are responsible for most of the decisions and processes that affect hospital utilization, that the groups make the investments necessary to develop processes to keep patients out of the hospital, and that, when patients are discharged sooner, the groups incur the costs of providing outpatient care in the post-discharge days. The groups would prefer to receive full risk capitation and then to devise risk-sharing, long-term contracts so that hospitals gain more from cooperating with utilization management than from prolonging patients' hospital stay.

Over the last decade, many California hospitals began to believe that acquisition of primary care physicians—perceived as a scarce resource—could make them stronger players in managed care competition, but their attempts to purchase medical groups were impeded by California's corporate practice of medicine law. They worked around this law by creating medical foundations which acquired some small medical groups, but larger groups resisted becoming part of what they believed would be hospital-controlled organizations. They feared that hospital-employed physicians

would not work as productively as physicians who owned their own group; that hospital executives did not know how to administer capitated physician practices; and that hospitals' objective was to keep their beds filled, rather than to create organizations that could profit from efficient management of utilization. The groups resisted PHOs for the same reasons, and they also believed that these loosely structured organizations would be inefficient. They saw little reason to surrender their independence to organizations that they believed hospitals would attempt to control.

With a surplus of hospital beds, and with California HMOs and medical groups growing and thereby acquiring increasing negotiating strength, many California hospitals in the 1990s face a future in which their very survival is at stake. Hospitals have responded in three ways: they have attempted to cut costs, to increase their own negotiating power and gain economies of scale by creating horizontally integrated hospital systems, and to acquire physician practices. Though large medical groups had articulated clear reasons why they were reluctant to sell to a hospital, the incentives to sell became very strong (as described in chapter 3). The groups basically had a choice of going public themselves (a technically difficult and risky route), of selling to a hospital system, or of selling to a physician practice management company (PPM). By 1996, two of the five groups profiled in this report, and eight of the thirteen groups we originally interviewed, had sold their practices to nonprofit hospital systems (Table 4). The hospital systems are now developing into organizations with separate arms: one to administer hospitals, and the other to act as a physician management company. Their concern is shifting from filling hospital beds to obtaining full risk contracts and managing care efficiently. Nearly 90% of the hospital admissions from the medical groups managed by UniHealth, for example, go to hospitals outside the UniHealth system.

In choosing between hospital systems and physician management companies, California medical groups consider a number of factors. A group's physicians may prefer to work with a nonprofit organization; with a respected local hospital, which is part of that organization; and with hospital administrators whom they know. They may also prefer to sell their practice entirely for cash, rather than for a combination of cash and stock in a publicly traded PPM, as is commonly the arrangement in acquisitions by the latter. (Physicians are usually required to wait for a specified interval of time before they may sell their stock in the organization which has acquired them.) On the other hand, they may prefer to have equity in the organization which now employs them; they may worry that the hospital's goal is to fill beds, and their years of experience with the local hospital's administrators may have resulted in distrust and disbelief in their ability to improve efficiency in physician practices. Some groups believe that publicly traded PPMs are more likely to have cutting edge medical information systems, as well as the kind of management skills which can help a medical group to improve its operations and its competitive position.

Whether either or both types of organization will succeed remains an open question. Both must try to increase their medical groups' efficiency, while avoiding the pitfall noted by Mullikin's John McDonald in the Sept. 1994 issue of *Health System Leader*. "As soon as a...system attempts to dominate a physician organization, they lose what they just bought."

## HOW DO CALIFORNIA MEDICAL GROUPS MANAGE CARE?

Beginning with their first HMO contracts, the medical groups profiled in this report, along

with many other groups in California, have been responsible for their own utilization management.<sup>39</sup> This contrasts with most of the rest of the United States, in which HMOs do much of the utilization management. During the past two decades the groups in this report have reduced hospital utilization, measured in bed days per thousand patients per year, to one-third of previous utilization. Their hospital utilization is lower than that of California medical groups and IPAs as a whole and much lower than that in other states with large numbers of HMO patients (Tables 6 and 7).

**Table 6: Hospital Days Per Thousand Commercial HMO Enrollees**

	<u>1983</u>	<u>1987</u>	<u>1990</u>	<u>1994</u>
Bristol Park Medical			162	136
Friendly Hills Medical			191	120
HealthCare Partners Medical			218	149
Mullikin Medical	525	359	166	139
Palo Alto Medical			n/a	140
California			250	206
Massachusetts			383	324
Minnesota			363	302
New York			359	345
U.S. HMO average			339	277

Source for medical group data: Medical group annual reports, UMGA statistics. Consistent statistics for the groups are not available prior to 1990, except for Mullikin.

Source for U.S. and state data: *Hoechst Marion Roussel HMO-PPO Digest*, 1995, and *Marion Merrell Dow Managed Care Digest*, 1991.

**Table 7: Hospital Days Per Thousand Medicare HMO Enrollees**

	<u>1990</u>	<u>1994</u>
Bristol Park Medical	-	905
Friendly Hills Medical	975	914
HealthCare Partners	850	936
Mullikin Medical	1,027	894
Palo Alto Medical	-	693
California	1,246	1,472
Massachusetts	1,628	2,367
Minnesota	1,591	2,074
New York	1,831	1,958
U.S. HMO average	1,628	1,682

Source: see Table 6.

How have the groups managed to achieve such a dramatic reduction? Are they more skillful in managing care, or do they benefit from favorable risk selection, or do they inappropriately restrict care? Quantitative data to answer to this question definitively do not exist. But it is possible to describe the changing incentives these medical groups face, as well as their evolving utilization management processes.

During the 1990s, the groups have been moving with increasing speed from:

1. Focusing on reducing costs to the improvement and documentation of quality.
2. Utilization review to utilization management.
3. Paying individual physicians based on the amount billed to devising payment systems intended to give physicians incentives to increase quality and patient satisfaction, while being attentive to the costs of care.

### **Increasing Focus on Demonstrating Quality**

These changes are occurring because the groups have been given incentives to make them, and, equally important, because they now have the capabilities to do so. By the 1990s, the groups were large enough and had sufficient prepaid cash flow to be able to invest in more utilization and quality management staff and in the expensive new computer data systems which were available. A group with 100,000 capitated commercial patients receives \$4 million or more a month in prepaid income for professional capitation alone; it may also receive some or all of the roughly \$4 million a month allocated by HMOs for hospital and other services. Medicare enrollees bring groups capitated payments that are three to four time larger. The groups now had the material resources and, after twenty years of managing care, the hard-won knowledge and experienced physicians and administrators necessary to think systematically about improving quality. Particularly in Southern California, they had developed their ability to manage care as part of a network of medical groups which, while simultaneously competing and cooperating, learned a great deal from each other. This learning occurred through close, informal contacts among leaders and members of the groups and, in a more organized way, through the trade association formed by the groups, the Unified Medical Groups Association (UMGA).<sup>40</sup> The UMGA provided educational meetings, help in learning to negotiate HMO contracts, and comparative financial and utilization data.

During the early 1990s, California's medical groups were abruptly given increased incentives to focus on the quality of care, or, at the very least, to focus on providing data on quality. The huge California Public Employees Retirement System (CALPERS) and the recently organized Pacific Business Group on Health (PBGH), a coalition of large corporate purchasers, emboldened by their recent success in controlling the growth of their medical care costs, now turned their attention to measuring quality. PBGH, for example, used the purchasing power of its member companies—\$3 billion in annual health expenditures—to push HMOs to provide quality and patient satisfaction data,

and began to put 2% of the premiums they paid HMOs in 1996 at risk for performance in those areas.<sup>41</sup> HMOs, in turn, began demanding more data from medical groups and moving toward putting a small fraction of the groups' capitation payments at risk based on this data. PBGH also initiated a variety of other quality efforts, including publishing an annual report card on HMOs, based on a survey of 20,000 of the coalition's employees and retirees, and collaborating with the UMGA groups to study quality and patient satisfaction.

Though quality measurements were still focused mainly at the HMO rather than the medical group level, and though little money was yet involved, the groups realized that to succeed during the next decade they would have to score well on quality measurements. They saw this as both a challenge and an opportunity, since they believed they would be able to perform better on these measurements than their competitors, particularly loosely structured IPAs.

"In the emerging era of managed healthcare, quality is the single factor that will distinguish one provider from another... Managed care providers are increasingly being asked to provide factual data that measure and demonstrate high quality of care. It is no longer enough to believe that the quality of care you deliver is the best. You must prove it."

—James Hillman, CEO, Unified Medical Group Association

In 1991, the UMGA created the Medical Quality Commission (MQC), an independent California nonprofit organization which sought to become the acknowledged accrediting agency for medical groups committed to managed care.<sup>42</sup> The Commission's accreditation teams assessed the performance of medical groups on 152 standards in fourteen major areas; the assessment included a site visit. By December, 1995, the MQC had given full accreditation to twenty-one medical groups and provisional accreditation to twelve, had deferred action on four groups, and had denied accreditation to one.

The new emphasis on quality and patient satisfaction gave medical groups a chance to interact directly with employers; previously HMOs had stood between employers and the groups. In 1996, for example, the MQC joined with PBGH to sponsor the "Physician Value Check," a study "aimed at providing participating groups with a statistically valid patient satisfaction/health status benchmark against other medical groups and IPAs, and a comprehensive data set that defines quality of care from the patient/employer perspective."<sup>43</sup>

### **From Utilization Review to Utilization Management**

The processes used to manage care by the groups during the 1980s were relatively primitive and labor intensive. Typically these processes—called utilization review (UR)—involved daily review of the progress of each hospitalized patient and pre-authorization of all referrals to specialists. Review was carried out by a group's utilization review nurses, who worked directly with the medical director.

Each group also had a utilization review committee. At Friendly Hills, for example, the physicians on the UR committee reviewed requests for expensive tests, for referrals outside the group, and for internal referrals of a type in which it is common for primary care physicians to dump patients onto specialists. For the past sixteen years, all the physicians at each Bristol Park practice site met weekly in Patient Care Committees to review referrals. Currently 15% of referrals reviewed by these committees are discussed and 8% are denied. In controversial cases, the physicians vote on whether to approve or deny a referral; when a referral is denied, the referring physician has the option to over-ride the committee and make the referral.

But as the groups grew, as competition intensified, and as the comparatively easy steps in managing care had already been taken (e.g., not admitting patients with low back pain to the hospital), the UR process yielded diminishing return. The process was too slow and labor intensive (the nine UR committee physicians at Friendly Hills were attempting to review 500-600 charts per week), and was inadequate to further reduce the costs and increase the quality of care. Though utilization review had some potential to improve quality by preventing unnecessary and possibly harmful care, its chief intent was clearly to control costs. Over the past decade, the groups have shifted their emphasis from the micromanagement of utilization review to the more pro-active processes of utilization management and quality improvement. These processes involve increased use of data and guidelines, systematic attempts to identify and correct problems, and an expansion of the way in which the groups think about quality.

Physicians are trained to feel fiercely responsible for their patients; they think of quality as the skill with which an individual physician cares for his or her patients. The groups profiled in this report are moving toward a broader view of quality: conceived not only as what an individual physician does for a single patient, but also as a function of the organizational processes created to help a group of physicians care for a population of patients.

The new care management processes developed by the groups may include:

1. *Case management.* Friendly Hills, for example, uses a three-tiered case management system:

- In each of four areas—maternal and child health as well as cardiac, pulmonary, and end stage renal disease—a clinical nurse specialist maintains telephone contact with patients who appear likely to benefit from case management.

- Four generalist case manager nurses follow patients with acute problems such as hip replacements and uncomplicated myocardial infarction, and also arrange services to prevent “care-giver burnout,” track patients who make multiple emergency room visits, and act as a liaison for patients who have many doctors involved in their care.

- Seven utilization management assistants arrange for services requested by the case management nurses, such as oxygen and durable medical equipment.

Many of the groups have recently developed “prehab” programs. For example, Bristol Park’s program, created in 1995, focuses on pre-admission preparation of all HMO patients scheduled to have hip or knee surgery. Patients are given written and in-person education by a physical therapist on what to expect after their operation. They are taught to use equipment, such as crutches, while they feel well, rather than in the weakened, painful post-op state. A social worker and/or nurse assesses their psycho-social needs, arranges in advance for necessary durable medical equipment, and helps the family plan for the care of the patient after discharge. Patients appreciate these programs, and they reduce the number of days spent in both acute care and rehabilitation facilities.

A UMGA White Paper, published in 1995, gave the groups’ ideal vision of case management:

Patients love case management...They know they can talk to someone about their case when they have concerns. They know a 24-hour hotline is available when they need it. Where traditional health care focused on the acute care of episodic illness, capitated health care must concentrate on avoiding the need for acute care. Case management, geared to carefully identified sub-populations, can be a huge factor in improving quality and reducing costs...The goal of case management is to prevent patient-driven and physician-driven underutilization and overutilization...At its best, case management enhances the clinician’s work by the addition of creative, supportive, and often nonclinical services that answer an individual patient’s needs. (Hillman, 1995)

2. *Specialized clinics* offer services like wound care and coumadin clinics.
3. *Urgent care centers* provide easy access to acute care for patients and reduce the number of emergency room visits. HealthCare Partners’ urgent care center, for example, is open 24 hours a day and provides care for 30,000 patient visits a year, of which 2,400 are sent to the center’s holding and observation area, where they may be treated for up to 24 hours without being admitted.
4. *Hospital teams* of physicians care for patients at the groups’ most-used hospitals. These physicians improve quality and reduce costs because they become highly skilled at inpatient care and are available to respond quickly to changes in a patient’s condition. The team physicians use specialists efficiently and become thoroughly familiar with clinical guidelines for the ideal timing of the sequence of care for a variety of acute illnesses. Reliance on a hospital team reduces the amount of utilization management of hospitalized patients required by a group. Patients and their families, as well as nurses, appreciate the easy availability of the hospital team physicians.
5. *Patient satisfaction surveys* provide feedback to individual physicians. For example, HealthCare Partners has employed an outside company to survey fifty patients per physician per year regarding their satisfaction with their care. Some of the groups have begun to ask physicians to evaluate each other, and to survey other staff as well.

6. *Patient education classes* are available at all the groups.
7. *Referral processes* have been streamlined. HealthCare Partners uses a three class method for authorization of referrals. Class I services do not require a referral and are not reviewed. Class II referrals, covering roughly 18 services, including such things as mammography, pelvic ultrasound, physical therapy, and mental health, do not require pre-authorization, but are reviewed retrospectively. Class III referrals, including services such as CT and MRI scans, thallium treadmills, arthroscopy, and electroencephalograms, require preauthorization.

Several of the groups permit patients to self-refer to certain types of specialists employed by the group, notably mental health specialists. For example, in 1992 HCP switched from contracting for mental health care to providing much of it in-house, using 22 full-time therapists, including seven psychologists, two psychiatrists, ten marriage and family counselors, and three chemical dependency counselors. The group permits patients to continue to see therapists even after their HMO insurance benefits (typically twenty visits a year) have been used up, as long as HCP's case managers believe patients will benefit from such services. HCP's belief is that patients will require fewer medically unnecessary physician visits and diagnostic tests if they have easy access to behavioral health services.

8. *Preventive care* encourages patients to seek appropriate care through organized outreach and follow-up systems.
9. *Unused referrals* are tracked and the referring physician is notified if a referral is not used.
10. *An appeals process* has been established by each group for patients and their physicians when referrals are denied. Appeals go to the medical director, the utilization management committee, and, if still unresolved, to the HMO.

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11. *Profiles of the referral patterns* of individual physicians have been developed. Because of the difficulty of risk adjustment for physicians who see more seriously ill patients, little or no financial reward is tied to these profiles, but they can be used to identify areas in which a physician may need further education, and they might ultimately be used to determine which physicians should be exempted from the old utilization review/preauthorization requirements.

12. *Continuous quality improvement* is beginning to be used in the groups. Figure 3 lists the QI activities of the Palo Alto Medical Clinic for 1996.

### **Figure 3: Palo Alto Medical Clinic Quality Improvement Activities, 1996**

#### **Completed Studies**

1. Pap/Cervical screening
6. HEDIS diabetic eye exam



- |                           |                                      |
|---------------------------|--------------------------------------|
| 2. Periodic health exams  | 7. HEDIS Pap smear rate              |
| 3. Access audits          | 8. HEDIS childhood immunization rate |
| 4. Senior flu             | 9. HEDIS pre-natal exam rate         |
| 5. HEDIS mammography rate | 10. HEDIS cholesterol screening rate |

In Process

- |  |   |
|--|---|
| 1. Diabetes best practice                        | 4. Colorectal screening                     |
| 2. Common follow-up system for health screenings | 5. Health risk appraisal                    |
| 3. Conscious sedation guidelines (standardize)   | 6. Congestive heart failure hospitalization |

Results of audits conducted by the groups can be used to reduce costs while improving quality. For example, Bristol Park analyzed emergency room visits and hospitalizations for its asthma patients and found that many were not using inhaled corticosteroids. Many had been seen in urgent care but had not received appropriate follow-up. Bristol Park’s Quality Management Committee then created guidelines for caring for the group’s asthma patients, including making it mandatory for physicians to refer them to the group’s Health Education Department. Among other things, the Department gives each patient a free spacer and peak flow meter and calls to make sure each has an annual flu shot. These activities represent added costs for Bristol Park, however, the group believes that they increase the quality of care, and preliminary figures indicate a 40% decrease in the cost of hospital and emergency room use for the group’s asthma patients in the first year of the program.

**Primary Care Physician Payment Methods**

“Capitation” is often discussed in the abstract, as if it were a single thing, but in fact there are many forms of capitation and a variety of organizational contexts in which capitation may be used. In some areas of the United States, HMOs pay individual physicians a capitated fee for their own professional services and may also place individual physicians at partial risk for the cost of specialist and hospital services used by the physician’s patients. Many IPAs in California do the same. Capitation in these contexts places individual physicians at full risk for the cost of their own services and at partial risk for some other costs of their patients’ care.

The medical groups profiled in this report are capitated by HMOs for all professional services and often for hospital and other medical services as well. The groups thus take on most—in some contracts nearly all—of the financial risk of caring for patients. But the groups do not capitate their own physicians. For many years after signing their first HMO contracts they continued to pay their physicians based on “productivity,” a traditional method in fee-for-service groups. Some groups divided a percentage of their revenue equally among physicians (in some cases senior physicians received a larger share) and divided the rest based on individual physicians’ productivity.

“Productivity” was typically measured by the amount a physician billed. Like fee-for-service, productivity-based pay gives physicians an incentive to do more than is necessary; by the late 1980s, Mullikin and HealthCare Partners had concluded that this was not compatible with capitated medical care and began experimenting with forms of salary-based payment.

Around 1993, as the groups faced increased pressure to demonstrate quality of care, all five

began to base their physician payment methods on a simple idea: "Let's decide what we want our physicians to do well, and then give them financial incentives to do it." By 1996, all five groups were basing roughly 25% of a physician's compensation on his or her performance in areas like patient satisfaction, peer and staff evaluations, and quality of care. Four of the groups paid the remaining 75% of compensation as salary, typically based on market rates, and in some cases adjusted for seniority. Bristol Park continued to base 75% of its compensation on productivity, believing that it is beneficial for physicians to have an incentive to see extra patients in a day when the patients want to be seen. The four salary-based groups set physicians' appointment schedules in such a way that they now see between 22 to 28 patients per day.

Friendly Hills and HealthCare Partners vary physician's compensation based on review of the physician's performance by a Compensation Committee; Mullikin's adjustment is made after review by the regional medical director. At Friendly Hills, the committee receives reports from each physician's department chair, from the Grievance Committee, from the medical director, from the Quality Improvement Committee, and from recently instituted patient satisfaction surveys and evaluations by other physicians and support staff. Bristol Park, HealthCare Partners, and the Palo Alto Medical Clinic use explicit formulas for determining how much of the 25% of compensation based on performance is paid to an individual physician.

For example, since 1994, Bristol Park has ranked and paid its physicians in the order of their scores on a "report card." Except for the top ten, who receive public recognition and an extra bonus, physicians are not identified by name, but each sees his or her own score and standing relative to other others. The report card is based on:

<u>Quality of Caring:</u>	<u>Percent of total points available:</u>
Patient satisfaction:	35%
Staff review:	15%
Peer review:	20%
Committee participation:	5%
 <u>Quality of Care:</u>	 10%
Diabetic retinal exams	
Mammograms	
Pap smears	
 <u>Disease Management Documentation:</u>	 5% (based on chart review)
 <u>Malpractice claims:</u>	 5%
 <u>UM nurse review:</u>	 5%

The ideal primary care physician in a capitated medical group works hard and is accessible

to patients; is liked and respected by colleagues, patients, and employees; focuses on preventive care and on improving the quality of his or her work; is conscious of the costs of care and tries to avoid unnecessary treatment; and contributes to improving the financial status of the group and the quality of the care it provides to its patient population . The medical groups profiled have tried to devise payment methods that will encourage the development of these qualities in their physicians. While the goal is obvious, the means to reach it are not. The groups must develop performance measures which both encourage the desired behaviors and are understandable and acceptable to their physicians. They must be able to generate the data necessary to actually use these measures. And they must balance the strength of the different incentives they give their physicians.

The payment methods used by the groups place surprisingly little emphasis on cost control; the amount of compensation based on an individual physician's costs of care is typically about 3% of the physician's total annual compensation. This calculation somewhat understates the physician's incentive to control costs, because if the group as a whole is more profitable, there will be more revenue to distribute to the physicians. But in groups as large as these this incentive is weak, because the actions of each individual physician have a relatively small effect on profitability, and that individual's share of any extra revenue will also be relatively small.

The bigger the percentage of physician compensation that is based on measures of performance, the more incentive physicians have to improve their performance in the areas measured. Why, then, haven't medical groups made the percentage larger than 25%? The most likely answer is that their physicians are reluctant to have an abrupt and extensive change in the way they are paid, and that the performance measures are still new and relatively untried, as is the data on which they are based. Cautious experimentation is likely to continue, driven both by changing incentives from purchasers and HMOs and by the physicians' desire to find payment methods that are perceived as fair.

“Every medical group has three methods for paying its physicians: the method we used last year, the method we are using this year, and the method we are going to use next year.”

—Guy Paquet, MD, Medical Director, Friendly Hills Healthcare Network

### **Assessment of the Medical Groups' Utilization and Quality Management**

Capitation has been called “the great liberator” (Governance Committee 1993, p. 56) because it frees physicians from financial dependence on the piece work of fee-for-service payments. By providing a predictable stream of prepaid revenue, capitation gives physicians the opportunity to think about how best to use that revenue to care for their population of patients. An opportunity given, however, is not necessarily an opportunity taken; physicians can also use capitation revenue to increase their personal incomes rather than to improve patient care. In the absence of quality competition, capitation provides extra profit for low cost providers whether they are of good

or poor quality.

The effect of capitation on quality may depend on the type of capitation used, on the type of physician organization involved, and on the other incentives affecting physicians. A physician capitated as an individual for all professional and hospital costs of patient care, with no other supervision or incentives, would have a very strong incentive to avoid providing and referring care for chronically ill patients. In contrast, physicians capitated as a part of a group that pays them using a salary plus bonuses, based on quality and patient satisfaction, are probably less likely to inappropriately withhold care, particularly if the group is subject to external accreditation and quality measurement.

In a judicious recent appraisal of capitation in the October 17, 1996 issue of the *New England Journal of Medicine*, Donald Berwick argues that:

Capitation most safely affects individual decisions through the intermediate filters of group process, consensus among peers, and clinical-policy formulation...The aim would be not to cause an individual doctor to consider the interactions between decision and profit in the case of a particular decision for a particular patient, but rather to induce physicians in group practices to consider the costs and benefits of clinical management patterns for patients of a general type in the longer run.

The incentives faced and processes used by the five medical groups described here match this description quite closely. Because the groups are large, and because utilization profiles are minor factors in the formulas used to determine the pay of individual physicians, the incentive for an individual physician to skimp on care for a patient is small. Individual physicians also have strong, positive quality incentives, including patient satisfaction, peer evaluation surveys, and various measures of the quality of their work—all of which are tied to their individual income. The group as a whole can save money by discouraging chronically ill patients from choosing or remaining with the group or from skimping on care, but a number of incentives point in the opposite direction. As Lynne Harshey, RN, Manager of Integrated Quality Services at Friendly Hills HealthCare Network points out, “We are repeatedly audited by each HMO, by the Health Care Financing Administration [for Medicare], and by the California Department of Health Services [for Medicaid]. We are accredited by the Medical Quality Commission. We have more oversight in a capitated environment than a fee-for-service physician could ever dream of.”

The utilization and quality management processes being developed by the groups profiled in this report appear to have the potential to contain medical care costs while increasing quality. But the processes are very new, and the pressures on the groups to hold costs down remain stronger than the pressures to increase quality. Nevertheless, although our study was not designed to search for quality shading, over the course of three years and nearly three hundred interviews, we did not encounter evidence of systematic denial of appropriate care. When asked in confidence about possible quality problems in California medical groups, industry executives outside the groups stated that there have been isolated problems, but not systematic denial of care, and that the five groups featured in this history have not been a concern. The medical director of one of the state’s largest HMOs recalled that a few years ago HealthCare Partners’ utilization statistics were so low

that they took a close look at the group and found that the care they were giving was excellent. The CEO of a large California HMO commented that:

“I think there has at times been inappropriate denial of care by medical groups and IPAs, but it tends to be episodic.

Since the late 1980s I have seen less inappropriate denial as the groups have become more experienced.

We did stop contracting with a few groups because they were denying care, but this was unusual; more often

we dropped groups because we believed they were insolvent. Until the late 1980s, two or three groups contracting with our HMO would go belly-up each year. As for the five groups you’re studying, there may have been inappropriate denial at times in the early days, but not since the groups grew. Prolonged patterns of denial would have caught up to them.”

Another HMO executive stated:

“I do have some concern about quality being shaded in the cases of patients who are very sick, especially children.

Docs want to keep these patients in the capitated network, when what they really need is to get into the hands of a

real expert. It’s typically an inexperienced IPA that will do the wrong thing here, in a misguided attempt to save money. Integrated groups have learned that it’s cheaper and better to get the patient into the right hands. Also, their ‘groupness’ leads to better care. If you put a group of doctors in a room together, there will always be one who will push for quality.”

### *Physicians’ Experience of Utilization Management*

For the majority of California and United States physicians practicing solo or in small groups, most of the utilization management processes described in this report are at best distant rumors. They experience managed care as an endless administrative nightmare in which they and their staff must deal with the multiple, varied, and ever-changing specialist and hospital referral panels and utilization review systems of all the IPAs and HMOs with which they contract. The physicians in the groups profiled in this report have a completely different experience of managed care: they deal with one utilization management system, created by their own organization, for their benefit. Dr. Sidney Hecker, of the Palo Alto Medical Clinic, states that during his time as medical director the group’s physicians cooperated because “the person calling them was a full-time practicing physician, a partner in the group, a four-time elected member of the executive board, and a friend.”

### *From Professional Quality to Corporate Quality*

Managed care is creating a historic shift in the United States from reliance on the professionalism of individual physicians to reliance on rationalized corporate, bureaucratic, data-based methods of quality control. This shift will result in higher quality of care for services which can be

measured easily, such as the percentage of women who appropriately receive mammograms and Pap smears, the percentage of children immunized, and the percentage of diabetics who receive annual eye exams. But unless the managed care system is structured carefully, quality measurements could have the unintended consequence of increasing quality in these areas while decreasing it in the many areas of medicine where measurement is more difficult. A medical director at a large HMO noted that every ounce of energy is being diverted to responding to the quality measurements currently being used; not one ounce of energy is going to any other aspect of quality.

Although this may be an exaggeration, it does put the problem starkly. Proponents of quality measures, like Antonio Legorreta, MD, Health Net Vice President of Quality Initiatives, argue that “You can’t improve anything until you can measure it.” But not everything that counts can be measured. To the degree that quality is not—and perhaps cannot—be measured, the safeguards for quality will be organizational processes and the professionalism of physicians. The professionalism of physicians—which stresses putting the interest of the patient above self-interest—may always have been a self-serving myth, at least in part. But insofar as it is real, the loss of the sense of responsibility for individual patients would be significant. The organizations in which physicians practice in California are changing rapidly; the effect that this will have on physician professionalism is unknown.

## CONCLUSIONS

Capitated medical groups are a new kind of organization, with new capabilities.<sup>44</sup> They provide an opportunity for innovation and improvement that did not exist in the fee-for-service, solo, and small group practice system of medical care. The fee-for-service system was geared to provide care for acute illnesses; the processes being developed by capitated medical groups should prove useful in caring for chronic diseases as well. The reorganization of physician practice driven by managed care in the United States could make the old dream of medical reformers a reality: to have groups of physicians thinking together about how best to care for populations of patients.

What actions by purchasers and by the federal and state governments might help this possibility become a reality? At present, legislators are trying to micro-regulate medical care, to the point of prescribing how individual medical conditions (e.g., childbirth) must be managed. A clear systemic goal would be preferable: to have groups of physicians caring for populations of patients and competing on both costs and quality, and to devise regulations that would facilitate the development of such a system. In particular, attention should be paid both to structuring incentives and to the types of physician organizations that are emerging.

### *Structuring Incentives*

1. HMOs and medical groups should not be penalized for excelling in the care of seriously ill patients. Therefore, risk adjustment of payments and of quality measurements should be done—insofar as it is feasible—both between purchasers and HMOs, and between HMOs and medical groups.
2. Quality measurement systems should be devised to minimize the possibility of quality of

care decreasing in the areas which are not being measured. HMOs and medical groups should be periodically evaluated based on quality measures which have not been specified in advance. If such evaluation exceeded an organizations' data collection capabilities, a list of possible quality areas, not specified in advance, could be created to evaluate the organization.

### *Focus on Types of Physician Organization*

Debates over managed care in the academic and policy literature, as well as in the mass media, tend to focus on HMOs and capitation. The information in this report indicates that debate might be more useful if it included attention to the types of organization of physician practice and if it specified the organizational structure in which capitation is being used. Who is paying capitation to whom, and for what services? Are HMOs paying full-risk capitation to medical groups? Or, conversely, are HMOs paying full-risk capitation to individual physicians? Failure to distinguish the implications of these two models is sure to generate more heat than light.

1. Purchasers, regulators, and researchers should have a clear understanding of the many ways in which physicians may be organized. At present, this includes medical groups like those profiled in this report; IPAs; HMOs directly contracting with individual physicians; staff model HMOs; and various forms of hospital-physician integration, including medical foundations and physician-hospital organizations (PHOs).
2. Each of these forms of physician practice organization may be owned and controlled on a local, regional, or national level. What are the comparative effects of the size and geographic range of these organizations on costs, quality, and the experience of patients and physicians?
3. If quality measurements and risk adjustment can be made with reasonable credibility, if physician organizations are already bearing most of the financial risk for medical care, and are doing their own utilization management, then more of the risk and reward for efficient, high quality performance should be focused at the level of the physician organization, rather than the HMO. At present, for example, California groups which have low costs and/or high quality are not rewarded with more patients because quality figures for the groups are not published and because the patient/purchaser pays the same premium to an HMO regardless of which physician organization the patient chooses.
4. Should physician organizations be permitted to take on full risk? The possible advantages of full risk contracting include more rational allocation of resources, coordination of care, increased accountability, decreased administrative complexity, and the incentive for providers to organize into groups and develop innovative processes for managing care. But many physician organizations lack the size, capital reserves, governance structures, and utilization management expertise to handle full risk without denying appropriate care or becoming insolvent. The history provided in this report suggests that it takes time to develop utilization management expertise—that it takes development of organizational processes and culture. UM expertise cannot simply be purchased and installed overnight.

## **Will the California Experience be Repeated in Other States?**

Is it possible for physicians in other parts of the United States to form medical groups like those which have been created over the past two decades in California? California's groups grew and learned to manage care under favorable circumstances. For 15 years, they enjoyed high capitation rates; they also enjoyed high rates of enrollment of new patients, but not so high that the groups couldn't manage their growth. At the start, both the groups and the HMOs were small: they cooperated together to create the new managed care industry. The groups were able to learn from each other, especially in Southern California, where a critical mass of groups cooperated and competed with an intensity analogous to the computer industry in Silicon Valley. No other types of organizations were competing to organize physician practices. PPMs did not exist, and California's corporate practice of medicine law made it harder for hospitals to employ physicians.

This favorable combination of circumstances probably does not exist currently in the United States. During the next five to ten years, the growth of managed care will lead to some form of organization of physician practice in metropolitan areas throughout the United States, but physicians who want to organize must compete with HMOs, with hospital systems, and with PPMs—all of which have more capital and administrative expertise than physician groups. If California's large medical groups (Mullikin at the time of its sale had more capitated patients than many HMOs around the United States) are almost unanimously choosing to join publicly-traded or hospital-managed PPMs, it is difficult to see how physicians elsewhere could organize successfully independently of these large organizations. Indeed, PPMs like Mullikin-MedPartners and San Diego-based FPA, which gained their experience with managing capitated contracts in California, are now using it to organize physicians in other states, bringing the organizational model of full-risk capitation and medical group management of utilization with them. The ultimate form and degree of success of these organizations, and the effects that they will have on the quality and costs of medical care, remain uncertain.



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## **INTERVIEWS**

Ferial Bahremand, VP for Network Development, Blue Cross of California, 11-13-96

Alan Barton, MD, former President, Bristol Park Medical Clinic, 9-12-96

David Druker, MD, President, Peninsula Coastal Region, Sutter/CHS, former Executive Director, Palo Alto Medical Group, and current COO, Palo Alto Medical Foundation, 8-1-96

Edward Geehr, MD, Senior VP, Strategic Development, and CMO, UniHealth, 6-27-96

Jack Hagadorn, MD, co-founder of the Bristol Park Medical Group, 5-30-96

Lynne Harshey, RN, Manager, Integrated Quality Services, Friendly Hills Healthcare Network, 9-27-96

Terry Hartshorn, President and CEO, UniHealth America, and former President and CEO of PacifiCare, 6-18-96

Sidney Hecker, MD, Assistant Director, Health Plans Office, Palo Alto Medical Foundation, 10-30-96

James Hillman, CEO, Unified Medical Group Association, 6-26-96

Allan Hoops, CEO, PacifiCare, 11-13-96

Robert Jamplis, MD, President and CEO, Palo Alto Medical Foundation, and former Executive Director of the Palo Alto Medical Group, 8-24-94

Judd Jessup, former TakeCare CEO, 7-31-96

Antonio Legorreta, MD, Health Net Vice President of Quality Initiatives, 9-27-95

Robert Margolis, MD, CEO and Managing Partner, HealthCare Partners Medical Group, 5-16-96

John McDonald, CEO, Mullikin Medical Center, 6-26-96

Robert Nelson, Senior VP, UniHealth Ventures, former Administrator of the Harriman Jones Medical Group, and former UMGA President, 5-30-96

Guy Paquet, MD, Medical Director, Friendly Hills Healthcare Network, 5-17-96

Marvin Rice, MD, Chairman of the Executive Committee, Friendly Hills Medical Group, 5-16-96

Burt Rose, Assistant Administrator, Palo Alto Medical Foundation, 8-1-96

Carlos Sobral, MD, family physician, Friendly Hills, 9-27-96

Elliot Sternberg, MD, Bristol Park Medical Director, 9-12-96

## ENDNOTES

<sup>1</sup> A company with twenty-five or more employees which offered health insurance must offer at least one federally qualified HMO, if one was present in the area.

<sup>2</sup> Interview with Burt Rose, Assistant Administrator, Palo Alto Medical Foundation, 8-1-96. The medical groups signed separate contracts with TakeCare, but negotiated as a group through the United Medical Clinics for the next decade until the new TakeCare CEO, Judd Jessup (whose father was a Palo Alto Medical Clinic physician), warned them that this was an anti-trust violation, and that TakeCare would no longer tolerate it.

<sup>3</sup> For example, Pacificare guaranteed that the groups would receive at least 70 percent of the income they would have received caring for Pacificare patients if they were paid fee-for-service. Interview with Terry Hartshorn, President and Chief Executive Officer, UniHealth America, and President and CEO of Pacificare from 1976 to 1993, 6-18-96.

Relatively new and expensive services, such as CT scans, were put into a category called “insured services,” which were not included in the capitated agreement; the groups could submit bills for the cost of these services. Over the years, the number of “insured services” has been decreased, as more services have been included under capitation or included in the hospital risk pool. Interview with Robert Nelson, Senior Vice President, Unihealth Ventures, former administrator of the Harriman Jones Medical Group, and former UMGA president, 5-30-96.

<sup>4</sup> HMO-controlled IPAs, in which HMOs contract directly with individual physicians, have been called “two-tiered IPAs;” while IPAs in which HMOs contract with the IPA, which in turn contracts with individual physicians, have been called “three-tiered IPAs” (Hillman 1992).

<sup>5</sup> This route had been taken by FHP, formed by Robert Gumbiner, MD, in 1966. The Roos-Loos Medical Group, which had been building a prepaid practice since the 1929, chiefly by contracting with local governments to cover their employees, was also in effect a staff model HMO, which was purchased by Cigna in the early 1980s.

<sup>6</sup> Furthermore, the example of the Kaiser Permanente Medical Group indicated that physician groups did have the capability to manage care.

<sup>7</sup> The source of the data is the groups’ annual reports, UMGA statistics, and, where necessary, personal communication with the groups. The groups also employed significant numbers of nurse practitioners, nurse midwives, physician assistants, psychologists, pharmacists, chiropractors, optometrists, and podiatrists. Friendly Hills data not available for 1985 and estimated for 1979.

<sup>8</sup> Accurate figures for the number of primary care physicians in each group prior to 1994 are not uniformly available, so we present these figures only for 1994. In calculating this percentage, we have counted obstetrician-gynecologists as specialists.

<sup>9</sup>HealthCare Partners figures through 1990 are for California Primary Physicians only; the 1994 figure is for the merged medical group formed by CPP and the Bay Shores and Huntington medical groups.

<sup>10</sup> “Commercial enrollees” are people who enroll with HMOs who do not have Medicare. Source of data: the groups’ annual reports, UMGA statistics, and, where necessary, personal communication with the groups.

<sup>11</sup> HealthCare Partners figures through 1990 are for California Primary Physicians only; the 1994 figure is for the merged medical group formed by CPP and the Bay Shores and Huntington medical groups.

<sup>12</sup> During 1993-1994, Mullikin acquired four medical groups in Northern California and attempted to sub-contract with hospitals there through its Pioneer Hospital, located southeast of Los Angeles. This drew particular attention.

<sup>13</sup> These include maintaining a minimum tangible net equity of at one million dollars or more, a deposit with the DOC or an authorized bank of \$300,000, and a fidelity bond of \$10,000 to \$20 million. The size of the tangible net equity and of the fidelity bond required depend on the number of HMO enrollees and the gross income of the organization.

<sup>14</sup> Of the thirteen groups that we originally interviewed, eight were still independent in 1994. By 1996, only two of the groups—HealthCare Partners and the Scripps Medical Group—remained independent.

<sup>15</sup> Some of the groups’ leaders believed that the market for practices was peaking, and that the right time to sell was now. “The reality is that this is a hot time to sell your practice, and a good business person sells when it’s hot.” (Interview with a medical group administrator.) Furthermore, by selling, the groups’ owners could avoid having all their eggs in the one basket of their equity in their medical group. Each could take the income received from the sale and distribute it among a variety of investments.

<sup>16</sup> Typically, each group practiced at multiple sites: between 1991 and 1993 Mullikin expanded from 19 sites in two regions to 42 sites in five Southern California regions.

<sup>17</sup> Mullikin made cash payments of \$4.8 million in partial payment for its 1992 acquisitions, committed to pay another \$4 million plus interest over the next six years, and issued 11,500 shares of stock to members of the acquired medical groups. Source: Mullikin Medical Center Annual Reports.

<sup>18</sup> The group completed all six mergers without taking any additional loans from banks. Though Mullikin’s stock was not publicly traded, it was clear by this time that the stock could be very profitably sold to an investor, or on the stock market, should MMC make the decision to do so.

<sup>19</sup> Source: Mullikin Medical Center Annual Reports.

<sup>20</sup> The remainder of the visits were fee-for-service MediCal (20%) and industrial (7%). By 1982, Medical visits had decreased to 3% of total visits, while industrial visits were 11%.

<sup>21</sup> Mullikin provided MIPA with about \$1.2 million over a four year period; most of this money had been repaid by the end of 1994.

22 Source: Mullikin Medical Center Annual Reports.

23 Mullikin Medical Center Annual Report, 1994. p. 17.

24 Mullikin was assisted in these acquisitions by \$30 million in cash and a \$20 million line of credit from The Daughters of Charity National Health System Western Region - one of the largest non-profit hospital systems in the United States; in exchange the Daughters received a 15% interest in Mullikin's holding company, Mullikin Medical Enterprises (MME), and a seat on the MME board.

25 The physicians signed personal guarantees on a \$30 million loan, which enabled them to buy the hospital and a good deal of surrounding land, and to refinance the debt which the group had previously accumulated in buying facilities and equipment.

26 The group was also able to benefit by using its ownership of the hospital to negotiate contracts giving Friendly Hills both the professional and the institutional fractions of the premium dollar - that is, to negotiate contracts which approached full risk.

27 A decade or more before, several California group group—Santa Barbara, Palo Alto, Scripps, Gould—had sold their assets to newly-created medical foundations. But these transactions had not been done within the context of managed care, nor had they involved hospitals, nor had they endured such close scrutiny from the IRS, which in dealing with Friendly Hills made clear that it was reconsidering the criteria which it would use to grant non-profit status to a medical foundation. The IRS guidelines issued for the Friendly Hills foundation stated, among other things, that the foundation must negotiate an arms-length, competitive contract for the services of the medical group, that it must conduct significant research and education, and that no more than 20% of its board could be physicians. The other seats were split between Loma Linda employees and community representatives chosen by Loma Linda.

28 Of the thirteen groups that we originally interviewed, the only other independent group in 1996 was the Scripps Medical Group, which had just left a foundation arrangement with the Scripps Institute, a hospital-dominated organization.

29 The term “recalibration” is taken from Kapsner (1994), p. 37.

30 Caremark was a national publicly traded physician management company. Sutter Health was a Sacramento-based hospital system that had been expanding throughout northern California, both through purchasing hospitals and through creating medical foundations with physician groups.

31 As sole corporate member, Sutter has three “reserve powers” which give it ultimate legal control selection of the Foundation's board members, selection of the CEO, and approval of the budget.

32 Hospitals formed medical foundations and management service organizations, which purchased the assets of medical groups. An HMO in California may legally employ physicians if the physicians treat only the patients of that HMO (this is the so-called “staff model HMO” exemplified in California by Cigna, FHP, and, to a lesser extent, by Foundation Health).

<sup>33</sup> Even when individual senior partners had more votes than newer partners, the relative proportion of votes held by senior partners grew less and less significant as the groups added new physician/owners.

<sup>34</sup> Number of new members in 1985, 1990, and 1994, divided by the total number of board members in those years.

<sup>35</sup> There were two CPP chief physician executives: Marshall Bernes, then Robert Margolis. William Chin was the chief physician executive at Huntington from the early 1980s until the merger with CPP. John Johnson was the chief physician executive at Bay Shores from the early 1980s until the merger.

<sup>36</sup> Again, this figure refers to CPP. Huntington and Bay Shores had only one lay chief executive each during these years, Larry Harrison and Marc Moser, respectively.

<sup>37</sup> Of the five executive committee members of CPP in 1985, three were on the board of HCP from the time of the merger in 1992 through 1995. They were joined by two physician board members each from Huntington and Bay Shores, including Drs. Chin and Johnson.

<sup>38</sup> The arguments are analogous to those regarding the improving the performance of physicians who are members of a group compared to those who contract with the group. Internal organizational processes for income division and for changing performance may be as difficult or more so than those between contracting organizations. It is, for example, difficult to fire a physician owner, and difficult to switch from using a poorly performing hospital which a group owns.

<sup>39</sup> For a current survey, see Kerr 1995.

<sup>40</sup> During the early 1980s the Unified Medical Groups (UMG), the organization which was formed to contract with the new Blue Cross HMO Communicare, was transformed into the UMGA. In recent years, the UMGA has changed from what was essentially a mutual support and education association for southern California medical groups to a multi-state organization engaged in public advocacy for capitated medical care and for a central role for organized groups of physicians in managing that care. By 1996 the UMGA had 88 member groups (of which 10 were newly-admitted IPAs) with 16,000 physicians and 4.5 million capitated HMO enrollees.

<sup>41</sup> Pat Powers, Executive Director of the Pacific Business Group on Health, speaking at the UMGA annual meeting, June, 1996.

<sup>42</sup> The Medical Quality Commission's board includes representatives of UMGA groups as well as employers, consultants, and HMO executives.

<sup>43</sup> The Medical Quality Commission 1995-1996 Annual Report, p. 11. Fifty-eight medical groups and IPAs are participating; one thousand randomly selected HMO patients from each will be surveyed twice, two years apart. The survey will provide risk-adjusted data on patient satisfaction, self-reported health and functional status, percent who received selected preventive services, and quality of care measures for two chronic conditions, hypertension and hypercholesterolemia.

<sup>44</sup> For many decades, the Kaiser Permanente Medical Group (TPMG) has been a prominent model of a capitated medical group; what is new is the large number of such groups, and the fact that, unlike TPMG, they each contract with multiple HMOs.