Title
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Journal
Health affairs (Project Hope), Suppl Web Exclusives

ISSN
0278-2715

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Publication Date
2001

Peer reviewed

Reevaluation Of Capitation Contracting In New York And California

The atmosphere between health plans and physicians is charged with distrust, as these two states' differing experiences show.

BY JAMES C. ROBINSON AND LAWRENCE P. CASALINO

ABSTRACT: We obtained detailed quantitative and interview data from Aetna U.S. Healthcare and six physician organizations to examine changes between 1998 and 2000 in the scope of capitation contracting and delegation of responsibility for claims payment and medical management in New York and California. The physician organizations in New York included Benchmark (Continuum), Montefiore IPA, and Lenox Hill Healthcare Network. In California they included Brown and Toland Medical Group, Monarch Healthcare, and Santa Clara County IPA. In both California, where global and shared risk capitation have been common, and New York, where they have not, we find movement to reduce the scope of prepayment and a rethinking of the delegated contractual relationship by physician organizations and health plans. This represents a departure from the 1990s, when many industry participants and analysts expected capitated and delegated relationships to spread across the nation.

CONTRACTUAL RELATIONSHIPS between health insurance plans and physician organizations are under severe strain. Many medical groups, independent practice associations (IPAs), and physician-hospital organizations (PHOs) were created and expanded during the 1990s in anticipation of a transfer of financial and clinical responsibilities from insurers to providers.[1] However, lower payment rates from Medicare and private insurers have undermined the attraction of global capitation to provider organizations, while increased regulation and liability have heightened worries within health plans concerning the delegation to providers of medical management and claims payment. To obtain in-depth information on the changes in capitation and delegation, we examined plan-provider relationships in New York and California, two large states that historically have stood at opposite ends of the managed care continuum, with New York physicians adhering to solo practice paid through fee-for-service (FFS) and California physicians forming medical groups paid through capitation. We obtained detailed quantitative and qualitative information from three prominent physician organizations in each state and from the nation's largest health plan, Aetna U.S. Healthcare, which has a large number of enrollees in both states.

Study Methods

We obtained 1998–2000 Aetna data for New York and California concerning enrollment,

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physician networks, scope of capitation financing, delegation of claims payment and medical management, and members' use of inpatient hospital services. Qualitative insights into Aetna's principles and practices of network contracting were obtained through semistructured interviews with executives, financial officers, medical directors, contract negotiators, and network managers at the national (corporate), regional (northeast and western), and metropolitan-area levels. We gleaned additional information from financial documents filed by the company with the U.S. Securities and Exchange Commission (SEC), reports and analyses by investment banking firms, and the insurance industry trade press.

"Case studies are particularly useful in studying the turbulent health care marketplace, where policy-relevant changes occur rapidly."

In New York we conducted case studies of the three physician organizations that have had major contracts with Aetna. (1) Benchmark Physician Organization was affiliated with Continuum Health Partners, a multihospital system in New York City that includes Beth Israel, St. Luke's-Roosevelt, and several smaller facilities. Continuum's hospitals employ numerous primary care physicians through a network of outpatient centers, have recently assumed control of several large primary care clinics formerly owned by the HIP staff-model health maintenance organization (HMO), and sponsor a network of physicians in independent practice.

(2) Lenox Hill Healthcare Network is the physician organization affiliated with Lenox Hill Hospital, a tertiary care institution in Manhattan, and several smaller community facilities in Queens. The physicians in the Lenox Hill network are primarily in independent practice, but the hospital recently acquired two large HIP primary care clinics.

(3) Montefiore Integrated Provider Association (MIPA) encompasses the faculty practice plan, primary care clinics, and independent (voluntary) physicians associated with Montefiore Medical Center, a multifacility delivery system in the Bronx and parts of Westchester County. We gathered data from each physician organization on the number of physicians and enrollees, extent of capitation financing, delegation of claims processing and medical management, and use of inpatient services. Qualitative information was obtained through interviews with medical group chief executive officers, operating officers, medical directors, board members, and managers at affiliated hospitals.

As a means of comparison with New York, we conducted case studies at three physician organizations in California, where capitation and delegation have been the dominant form of managed care for more than a decade.[2] (1) Brown and Toland Medical Group is a physician-owned IPA in San Francisco, formerly associated with the California Pacific Medical Center and University of California hospitals but now independent. (2) Monarch Healthcare is an IPA in Orange County, the large suburban region south of Los Angeles. Monarch was originally formed through the merger of three hospital-affiliated IPAs but now is independent and physician owned. (3) The Santa Clara County IPA (SCCIPA) is a large physician-owned IPA in the Silicon Valley region near San Jose. We obtained data and interview information from these three IPAs analogous to what we collected in New York.

We discussed each of the six physician organizations with the Aetna managers and medical directors in the respective markets and discussed Aetna's relationship with each one. We verified this information through interviews with competing medical groups, physician practice management (PPM) firms, hospitals, and health insurance plans. We gained insights into the larger market context from interviews with regulators, corporate purchasers of health insurance benefits, and policymakers in both states. The triple foci of

the case studies (Aetna, the six medical groups, and knowledgeable persons outside these organizations) facilitated triangulation, a method of case study research involving the comparison and cross-checking of information from multiple sources.[3] Case studies and triangulation are particularly useful in studying the turbulent health care marketplace, where policy-relevant changes occur rapidly and where only limited timely, quantitative data are available.

Enrollment And Network Development

Total Aetna enrollment grew between January 1998 and January 2000 by 57 percent in California and 34 percent in New York, primarily as a result of Aetna's acquisition of the health insurance operations of New York Life Insurance Company and the Prudential Insurance Company (Exhibit 1). The importance of physician organizations in the insurer's networks varied greatly between the two states.

EXHIBIT 1
Physician Network, Capitation Contracting, And Delegation Of Managed Care Functions By Aetna U.S. Healthcare In California And New York, 1998–2000

	California		New York	
	1998	2000	1998	2000
Enrollment				
Commercial HMO	300,104	692,423	434,619	530,967
Medicare HMO	83,847	65,497	30,851	77,399
Point-of-service plan	2,822	142,487	227,838	375,840
Preferred provider organization	593,420	734,954	285,374	413,920
Indemnity plan	125,652	102,345	167,222	122,285
Total	1,105,845	1,737,706	1,145,904	1,530,411
Physician network				
Primary care physicians	8,926	10,096	4,182	5,808
Specialists	17,533	19,493	8,210	10,996
Contracted physician organizations				
Commercial HMO	272	245	6	3
Medicare HMO	136	150	6	3
Enrollees in physician organizations				
Commercial HMO	92.7%	93.4%	13.0%	12.2%
Medicare HMO	96.0	97.2	8.4	2.7
Global capitation				
Commercial HMO	44.0%	41.5%	5.7%	5.9%
Medicare HMO	59.9	88.6	3.2	1.3
Professional services capitation				
Commercial HMO	48.7%	51.9%	7.3%	6.3%
Medicare HMO	36.1	8.6	5.2	1.4
Delegation of claims payment to physician organizations				
Commercial HMO	95.0%	95.0%	0.0%	2.1%
Medicare HMO	95.0	95.0	1.3	1.3
Delegation of inpatient medical management to physician organizations				
Commercial HMO	54.0%	46.0%	2.5%	2.1%
Medicare HMO	65.0	90.0	1.3	1.3
Inpatient days per 1,000 enrollees				
Commercial HMO	173	172	241	189
Medicare HMO	1,214	1,349	1,717	1,498

SOURCE: Data provided by Aetna U.S. Healthcare.
NOTE: HMO is health maintenance organization.

In 2000, 93 percent of Aetna's commercial HMO enrollment in California was covered by capitated contracts with 245 medical groups and IPAs, while in New York Aetna contracted with only three physician organizations, which collectively covered 12 percent of the plan's commercial HMO enrollment. The remaining 88 percent of enrollees were covered by contracts signed between the insurer and individual physicians.

The three IPAs in California experienced increases in patient enrollment during this period and, in two cases, increases in the number of physician members (Exhibit 2). These represent the net effect of two underlying trends. Many California physician groups were retrenching from earlier geographic expansions, refocusing on their core communities, and dropping physicians and patients in outlying areas. Yet they simultaneously were adding patients and physicians in their core communities, as erstwhile medical group competitors floundered. In New York both Benchmark and Lenox Hill expanded their physician networks and increased patient enrollment, while Montefiore maintained a stable network with growing enrollment (Exhibit 3). All three IPAs anticipated enrollment

EXHIBIT 2
Trends In Patient Volume, Physician Participation, Capitation Contracting, And Managed Care In Three California Physician Organizations, 1998–2000

	Brown and Toland Medical		Monarch Healthcare		Santa Clara County IPA	
	1998	2000	1998	2000	1998	2000
Physician membership						
Primary care physicians	364	513	140	220	300	281
Specialists	1,266	2,111	245	526	536	432
Number of health plans						
Commercial	14	10	15	10	13	11
Medicare	6	4	6	7	8	3
Patient enrollment						
Commercial						
Aetna	13,907	22,647	3,802	7,490	22,581	18,276
Other	154,018	185,867	76,464	110,210	75,829	101,188
Medicare						
Aetna	1,145	1,540	724	755	2,933	2,035
Other	15,378	17,981	13,453	20,045	6,202	8,237
Total	184,448	228,035	94,443	138,500	112,888	132,548
Global capitation						
Commercial	68%	57%	30%	30%	21%	0%
Medicare	100	0	90	75	93	0
Professional services capitation						
Commercial	32%	43%	70%	70%	79%	100%
Medicare	0	100	10	25	7	100
Delegation of claims payment	100%	100%	100%	100%	100%	100%
Delegation of inpatient medical management	100	100	100	100	80	86
Inpatient days per 1,000 enrollees						
Commercial	141	157	141	190	165	155
Medicare	871	1,107	1,091	1,124	1,300	1,350

SOURCE: Data provided by the three organizations.
NOTES: Total patient enrollment includes prepaid Medicaid beneficiaries in addition to commercial and Medicare enrollees. IPA is independent practice association.

EXHIBIT 3
Trends In Patient Volume, Physician Participation, Capitation Contracting, And Managed Care In Three New York Physician Organizations, 1998–2000

	Benchmark Physician Organization		Montefiore Integrated Provider Association		Lenox Hill Healthcare Network	
	1998	2000	1998	2000	1998	2000
Physician membership						
Primary care physicians	267	453	244	248	120	246
Specialists	643	1,007	849	856	330	400
Number of health plans						
Commercial	1	2	6	5	1	4
Medicare	1	1	3	5	0	2
Patient enrollment						
Commercial						
Aetna	22,000	37,000	16,000	24,000	0	32,000
Other	0	7,000	17,000	19,000	36,000	58,000
Medicare						
Aetna	600	0	200	1,000	0	2,000
Other	0	0	3,900	6,200	0	9,000
Total	22,600	44,000	37,100	50,000	36,000	101,000
Global capitation[a]						
Commercial	100%	100%	96%	97%	0%	3%
Medicare	100	–[b]	100	100	–[b]	82
Professional services capitation[a]						
Commercial	0%	0%	4%	3%	0%	40%
Medicare	0	–[b]	0	0	–[b]	18
Delegation of claims payment	0%	0%	100%	100%	0%	0%
Delegation of inpatient medical management	0	0	85	85	0	0
Inpatient days per 1,000 enrollees						
Commercial	–[b]	260	277	232	300	280
Medicare	–[b]	–[b]	2,100	2,250	2,200	1,700

SOURCE: Data provided by the three organizations.
NOTE: Total patient enrollment includes prepaid Medicaid beneficiaries in addition to commercial and Medicare enrollees.
[a] Although these types of capitation were widely used in the three organizations that we studied, they were less common in New York State as a whole.
[b] Not available.

increases consequent to their assuming responsibility for the clinics formerly owned by the HIP staff-model HMO in New York.

Capitation Payment

The allocation of financial responsibility between health plans and physician organizations depends on the breadth of services covered by capitation payment. The greater the number of services covered by capitation, the greater is the medical group's authority to allocate resources as it sees fit, but also the greater is its exposure to unanticipated increases in costs. Several years ago both Aetna U.S. Healthcare and the physician organizations studied here anticipated a move toward contracts placing a greater number of services under capitation, extending from prepayment

for all professional services (primary and specialty physician services) to global (physician and hospital) capitation. As indicated in Exhibit 1, the Aetna HMO network in California remains heavily financed through capitation payment. More than 90 percent of commercial enrollees were covered under capitation contracts in 2000, with 42 percent covered by global capitation and an additional 52 percent covered by professional services capitation in which financial responsibility for hospital costs is shared between the health plan and the physician organization. The percentage of enrollment in the Medicare HMO product covered by global capitation grew from 60 percent to 87 percent, as a result of Aetna's decision to exit several counties and drop IPAs that would not shift to global capitation.[4] In New York global and professional services capitation continues to cover a very small part of the Aetna enrollment, mirroring the small role played by physician organizations in that state.

"Health plans in both states are concerned with the financial solvency and the claims payment practices of their contracting medical groups."

Although global and professional services capitation were uncommon in New York, they were present to varying degrees in the three New York physician organizations studied here (Exhibit 3). Enrollment in the New York IPAs was almost completely covered by global capitation, consistent with the strong ownership linkages between these physician groups and their sponsoring hospital systems. Hospital systems in New York interpreted global capitation as a means for attracting primary care physicians to the hospital medical staffs. These physicians were expected to admit their FFS as well as their HMO patients to the sponsoring hospitals when inpatient care is needed. The Lenox Hill Healthcare Network, for example, expanded into Queens to recruit primary care physicians who were willing to refer their tertiary care admissions into the Manhattan institution, while using smaller Queens hospitals for routine admissions. Benchmark was sponsored by Continuum Health Partners to help its member facilities compete for admissions against multihospital systems such as New York Presbyterian and Mt. Sinai NYU (New York University).

During this recent period the fraction of revenue received by the three California IPAs through global capitation declined, especially for Medicare HMO enrollees. Brown and Toland and SCCIPA, which in 1998 had almost all of their Medicare patients covered by global capitation, had converted completely to professional services capitation (with shared risk for hospital services) for Aetna patients by 2000. Brown and Toland's hospital partners, California Pacific Medical Center and the University of California, unilaterally renounced capitation and reverted to discounted FFS (per diem) contracts. SCCIPA allowed its global capitation contracts to lapse as a result of continued tensions with the dominant local hospital system in its area, HCA, over data and financial management related to the capitation revenues.

Claims Processing And Payment

In New York Aetna has adhered to its preferred national strategy of not delegating claims processing and payment. The direct payment of claims provides Aetna with data on utilization that are otherwise difficult to obtain and enables the health plan to track whether physician organizations are exceeding their capitated budgets. In California, however, the delegation of claims processing to physician groups has historically been part of the relationship between HMOs and medical groups, and Aetna has accepted it. Almost all patients in Aetna's California HMO are enrolled in physician organizations that have been delegated claims payment, whereas almost none of Aetna's New York HMO mem-

bers are in delegated relationships (Exhibit 1). Analogous differences between the two states exist for other health plans: The three California IPAs are delegated for claims payment by all plans, whereas only one of the three New York physician organizations is delegated for these functions (Exhibits 2 and 3).

Health plans in New York and California are increasingly concerned with both the financial solvency and the claims payment practices of their contracting medical groups. Aetna has greatly increased its auditing of the groups' financial status, including annual and quarterly financial statements and reports on monthly cash flow, methods for projecting revenues (for example, expected earnings on shared risk pools), and methods for projecting costs (for example, incurred but not reported claims). Aetna also has sought to require that physician organizations to which claims payment is delegated provide letters of credit from banks or other financial institutions that would indemnify the insurer against losses due to IPA insolvency. It has not achieved much success in this effort.[5]

Aetna and other health plans in New York and California are intensifying their oversight and auditing of claims payment practices by delegated physician organizations, including the percentage of claims denied, percentage returned for additional documentation, and percentage paid within specified periods. The criteria are not developed by the plans but are dictated by requirements from the Health Care Financing Administration (HCFA, for Medicare HMO products), the state departments of insurance and managed care (for commercial HMO products), and the National Committee for Quality Assurance (NCQA, for large corporate purchasers of health benefits). All participants in this study reported strong tensions over claims payment, with continual disputes concerning oversight and de-delegation. Brown and Toland almost lost delegation in the wake of its financial difficulties in 1998; it retained delegation for payment of physician claims but relinquished payment of hospital claims as part of its abandonment of global capitation. SCCIPA has resisted efforts at de-delegation of claims payment, viewing this as the first step toward full termination of the IPA's Aetna contract and initiation of direct Aetna contracting with individual physicians.

Medical Management And Use Of Hospital Services

Both health plans and physician organizations engage in medical management, seeking to monitor and modify patterns of specialty referral, ambulatory testing, inpatient admission, and length-of-stay, and also by providing case management for patients with serious chronic diseases. In the context of wide geographic variations in clinical practice styles, lack of consensus on definitions of medically necessary care, and financial incentives to provide either excessive or inadequate treatment, however, medical management has become highly controversial. Consumer organizations, politicians, the media, regulatory agencies, and trial lawyers have increased their oversight of health insurance plans, which in turn are increasing their oversight of physician organizations. The plans' emphasis now is shifting from attempts to limit utilization to attempts to ensure that capitated physician organizations do not inappropriately deny services. Aetna has reversed its trend toward delegation of medical management and maintains a corporate policy that the firm should not be at higher risk of litigation in contexts where it delegates medical management to physician organizations than it is in contexts where it contracts directly with individual physicians and does medical management itself.

The area of medical management most under reconsideration is "concurrent" review of hospital utilization, which focuses on length-of-stay and discharge planning. As indicated in Exhibit 1, most physician organizations in California retain authority for medical management under Aetna contracts to the extent that they are fully capitated for hospital services but share responsibility when they are capitated for professional services and share responsibility with the health plan for the

cost of hospital services. In 2000, for example, the percentage of Aetna enrollees in California physician organizations delegated for concurrent review was virtually identical to the percentage in organizations under global capitation. In New York, however, Aetna has almost completely avoided delegation of concurrent review.

Large, well-established physician organizations typically are delegated to perform more managed care functions. As indicated in Exhibit 2, the three California IPAs remained extensively delegated for inpatient medical management by most HMOs, despite having shifted from global to professional services capitation. Brown and Toland and Monarch Healthcare were delegated medical management by all of their health plans, while SCCIPA was delegated by all health plans except Aetna. In New York, Montefiore was delegated for concurrent review by some plans but not by Aetna. Benchmark and Lenox Hill, both of which are new to capitation, were not delegated authority for concurrent review, although each performed "shadow medical management," reviewing patterns of care and recommending actions to the health plans, which retained authority to approve or deny a request.

"The backlash against medical management has induced many physician organizations to shift care back into the hospital setting."

Medical groups and IPAs in California historically have led the nation in shifting care from inpatient to subacute and outpatient settings, generating the lowest rates of inpatient utilization.[6] Over the past two years, however, the backlash against medical management has induced many physician organizations to shift care back into the hospital setting. Between 1998 and 2000, rates of inpatient utilization for Aetna in California remained stable for commercial HMO enrollees but increased by 27 percent for Medicare enrollees (Exhibit 1). Analogous trends were experienced by other health plans, as evidenced in the rates reported in Exhibit 2 for the three California medical groups. Hospital utilization for commercial enrollees rose during this period by 11 percent for Brown and Toland and 35 percent for Monarch, while it rose for Medicare patients by 27 percent and 3 percent, respectively. SCCIPA experienced small declines in utilization for commercial patients and small increases for Medicare patients. The rates in Exhibit 2 are all much higher than rates reported for California medical groups in 1990 and 1994.[7] Rates of hospital use have continued to decline in New York, because of the high baseline utilization rates and continued efforts by both the HMOs and physician organizations. Hospital days per 1,000 enrollees declined during this two-year period by 21 percent for Aetna's commercial enrollees and by 13 percent for its Medicare enrollees (Exhibit 1).

Conclusion

In California, where medical groups and IPAs are common, the basic contractual structure of capitation and delegation remains in place, but the scope of services subject to capitation is being reduced and health plans' monitoring of claims processing and medical management is being intensified. In New York, where large medical groups and IPAs are uncommon, health plans are retaining responsibility for network development, provider payment, claims processing, and medical management and are reconsidering their willingness to contract with physician organizations at all.

The reevaluation of plan-physician contracts is being conducted in a charged atmosphere of distrust. The relationships between Aetna and the six physician organizations studied here have continued to deteriorate. In June 2000, after these data were collected, Brown and Toland Medical Group sued Aetna alleging fraudulent provision of incomplete eligibility data and consequent underpayment of contracted capitation rates. Continuum Health Partners unilaterally terminated its

global capitation contract with Aetna, reverting back to FFS hospital payment and dissolving the Benchmark IPA. Aetna has increased its contracting on an individual basis with physicians in several parts of California, including portions of San Mateo County previously served by SCCIPA, Brown and Toland, and other IPAs.

THE HEALTH CARE SYSTEM is passing through a period of turmoil and transformation. Increased oversight by health plans and governmental agencies may weed out weaker physician organizations and stabilize the finances and medical management systems of those that remain, thereby leading to a revival of the medical group role in managed care. Alternatively, the changing environment may prove inimical to large physician organization and foster a return to solo and small-group practice, paid on a discounted FFS basis and monitored by outside entities, as the dominant organizational structure for medical care delivery.

This research was supported by the Robert Wood Johnson Foundation.

NOTES

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3. R.K. Yin, *Case Study Research: Design and Methods*, 2d ed. (Thousand Oaks, Calif.: Sage Publications, 1994); S.M. Shortell, "The Emergence of Qualitative Methods in Health Services Research," *Health Services Research* (December 1999): 1083–1091; and R.E. Hurley, "Qualitative Research and the Profound Grasp of the Obvious," *Health Services Research* (December 1999): 1119–1136.
4. The apparent increase in number of contracting IPAs in the Medicare network, from 136 to 150, is an artifact of the breakup of several large provider organizations into multiple independent medical groups.
5. The state governments in both California and New York are considering regulations that would require capitated physician organizations to maintain reserves and other financial solvency guarantees.
6. Robinson, *The Corporate Practice of Medicine*.
7. J.C. Robinson and L.P. Casalino, "The Growth of Medical Groups Paid through Capitation in California," *New England Journal of Medicine* 333, no. 25 (1995): 1684–1687.