

# California State Auditor

B U R E A U O F S T A T E A U D I T S

## Health Care Payment Surveys:

*Providers and Payers Have Differing Views  
Over a Complex, Sometimes Unregulated,  
Health Care System*



March 1999  
98104

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# CALIFORNIA STATE AUDITOR

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March 30, 1999

98104

The Governor of California  
President pro Tempore of the Senate  
Speaker of the Assembly  
State Capitol  
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its report concerning the extent to which physicians and medical groups believe they receive late payments for their services and the effect any delays may have on their practices.

Based on the results of our surveys, this report concludes that 51 percent of physicians and 74 percent of medical groups report problems with some kind of delay in payments for their services. Fee-for-service payments from independent practice associations (IPAs), preferred provider organizations, and point of service plans came in for the most criticism from medical service providers. Twenty-eight percent of the physicians and 38 percent of the medical groups responding to our survey claim that delays negatively affected the fiscal aspects of their practices. However, few reported that delays affect their patient care.

In contrast, health plans and health care intermediaries report few payment difficulties and report that they receive and make most payments within reasonable time frames. Medical groups, IPAs, and management services organizations expressed concerns over the accuracy of the enrollment data on which capitation payments are based, as well as some problems with health care plans' distribution of risk pool moneys. The survey results have implications for California's regulatory structure over its health care industry. In particular, some health plans and intermediaries are either indirectly regulated by the State or not at all.

Respectfully submitted,

A handwritten signature in cursive script, reading "Kurt R. Sjoberg".

KURT R. SJOBERG  
State Auditor

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# SUMMARY

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## Audit Highlights . . .

*Our surveys of 1,300 physicians, 1,025 medical groups, and a cross section of health care payers from health maintenance organizations (HMOs) and preferred provider organizations (PPOs) to a variety of intermediaries, including independent practice associations (IPAs) and management services organizations revealed:*

- One-half of the providers cited some delays in payments.*
- Fee-for-service claims paid by IPAs, PPOs, and point of service plans were the most frequently cited type of delayed payment.*
- Approximately one-third of providers indicated that delayed payments negatively affected the fiscal aspects of their practices, but few reported an impact on patient care.*
- Very few health care payers reported payment difficulties and most believe they make and receive payments on time.*

*Finally, our results bring to light the complex nature of the health care industry and the disparity in regulation: some entities are heavily regulated and others have little or no state oversight.*

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## RESULTS IN BRIEF

In an effort to slow significant increases in costs, the health care industry in California has evolved over the last 20 years from a traditional indemnity insurance environment to managed care. Through its efforts to curb costs, managed care has generated criticism concerning its impact on the quality of medical care, effectiveness of regulation, and financial soundness of the health care industry. Furthermore, recent bankruptcies within the health care industry have heightened these concerns. One aspect of these concerns, the extent of delayed payments to physicians and its effect on their practices, is the subject of this report.

The flow of payments to physicians, though once a simple and direct payment from the patient or the insurance company, can be complicated under managed care. What most consumers do not know is that most payments originating with a health plan pass through one or more intermediaries before reaching the physician. To develop a full picture of this flow of payment, we surveyed representatives of all types of health care entities: the providers of services, which include physicians and the medical groups to which they belong, and the payers for services, which are the health plans and intermediaries responsible for performing administrative functions for providers they contract with. Medical groups have a dual role, functioning as intermediaries and providers, and their survey questions and responses reflect both of these roles.

To ascertain whether physicians and medical groups are experiencing difficulties receiving payments under a managed care environment, we surveyed 1,300 physicians, 1,025 medical groups, and a cross-section of health care payers, from health maintenance organizations (HMOs) and preferred provider organizations (PPOs) to a variety of intermediaries performing administrative functions, such as independent practice associations (IPAs) and management services organizations (MSOs).

One-half of the physicians cited some delays in payments from one or more of the health care payers with whom they have experience. Overall, about 51 percent of physicians responded

that HMOs, IPAs, or medical groups pay their capitation or fee-for-service claims late. Fee-for-service claims paid by IPAs were a frequently cited type of delayed payment, but late HMO capitation payments and tardy medical group reimbursements were also mentioned. Similarly, 74 percent of medical groups reported experiencing some type of delayed payment from HMOs or IPAs for either capitation or fee-for-service payments. In addition, some medical groups expressed frustration with errors in enrollment lists supporting capitation payments. In response to our query about the impact of delayed payments on their practices, 28 percent of the physicians and 38 percent of the medical groups claim that delayed payments negatively affected the fiscal aspects of their practices. However, few indicate that delays affect their patient care.

It is in the area of timing of payments that responses from providers and payers are the most divergent. Interestingly, very few health care payers reported delays, and most believe they receive and make payments within reasonable time frames. Specifically, health care payers state that capitation and fee-for-service payments are timely. However, 25 percent of both the MSOs and IPAs cited some experience with inaccurate enrollment data. In addition, the majority of medical care payers indicated that they pay uncontested claims within 45 days. Despite advances in electronic commerce, very few of the intermediaries responded that they pay claims electronically.

Different entities reported varying experiences related to risk pool distributions. A risk pool is an arrangement between a health plan and an IPA or medical group in which both share the risk of the cost of designated services. MSOs and IPAs were generally satisfied with the timing of the distribution. However, nearly half of the intermediaries, including some medical groups, report contesting at least part of their risk pool distributions from HMOs and point of service plans.

Furthermore, three-quarters of medical groups claim they rarely or never receive interest on delayed payments from health plans. This is similar to the experience of MSOs. In addition, some medical groups indicated that IPAs sometimes pay less than the contracted rate on fee-for-service claims.

The results from our surveys have implications for California's regulatory structure over its health care industry. In some areas, the industry is heavily regulated, but in others, there is little or no regulation. For example, while the State does not regulate

intermediary entities, respondents to our surveys expressed concerns about delayed payments from IPAs. Also, many PPOs, which are the second most common type of health plan in California, are not subject to direct state regulation.

Moreover, some of the current statutory and regulatory controls are weakened because of the impact of intermediaries on the industry. For instance, regulations requiring prompt reimbursement of providers' claims are difficult to enforce when the payments pass through several hands before reaching the providers.

Finally, the surveys indicated that the differing perspectives communicated in the responses from providers and payers are affected by the complexity in the administration of the health care industry and that clearer communication of vital information is needed.

## RECOMMENDATIONS

The Legislature should consider doing the following:

- Establish direct state regulation over the activities of health plans not currently regulated or monitored and replace the current, redundant oversight by health plans over health care intermediaries with centralized state regulation. As part of this regulation, consider requiring all involved entities to provide at least semiannual financial statements as well as the annual audited financial statements to a designated state regulatory department.
- Require health plans to submit to providers and intermediaries enrollment lists that are the basis for capitation payments. Thus, the data for the payment should be identical to the information on the enrollment lists.
- Reexamine the provisions of the Knox-Keene Health Care Service Plan Act of 1975 related to the limitation on health plans' administrative fees when intermediaries take on some of several administrative functions of health plans. Also, consider establishing limits on administrative fees charged by intermediaries and a system for centrally monitoring the compliance of all applicable health care entities with these limits. ■

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# INTRODUCTION

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## BACKGROUND

**B**ecause health care is expensive, health insurance in one form or another has become a necessity of life for California consumers. Over the last 20 years, however, the health care industry has changed substantially as it evolved from a health insurance, or indemnity, environment to managed care in an effort to contain ever-increasing costs that rose faster than the inflation rate. The result is a series of complicated, and sometimes contentious, relationships between a variety of health care plans, employers, employer purchasing groups, government agencies, providers of medical services, and consumers.

While managed care has slowed the increases in health care costs, it has raised other widespread concerns. The debates have ranged over a variety of topics including the quality of medical care, low payment rates to providers, what should be considered besides cost when a consumer needs medical care, who oversees entities not considered subject to the main bodies of law on managed care, and who pays providers when bankrupt companies can no longer pay claims. Recent bankruptcies and government seizures of financially troubled health care entities have heightened concerns about the fiscal soundness of the industry.

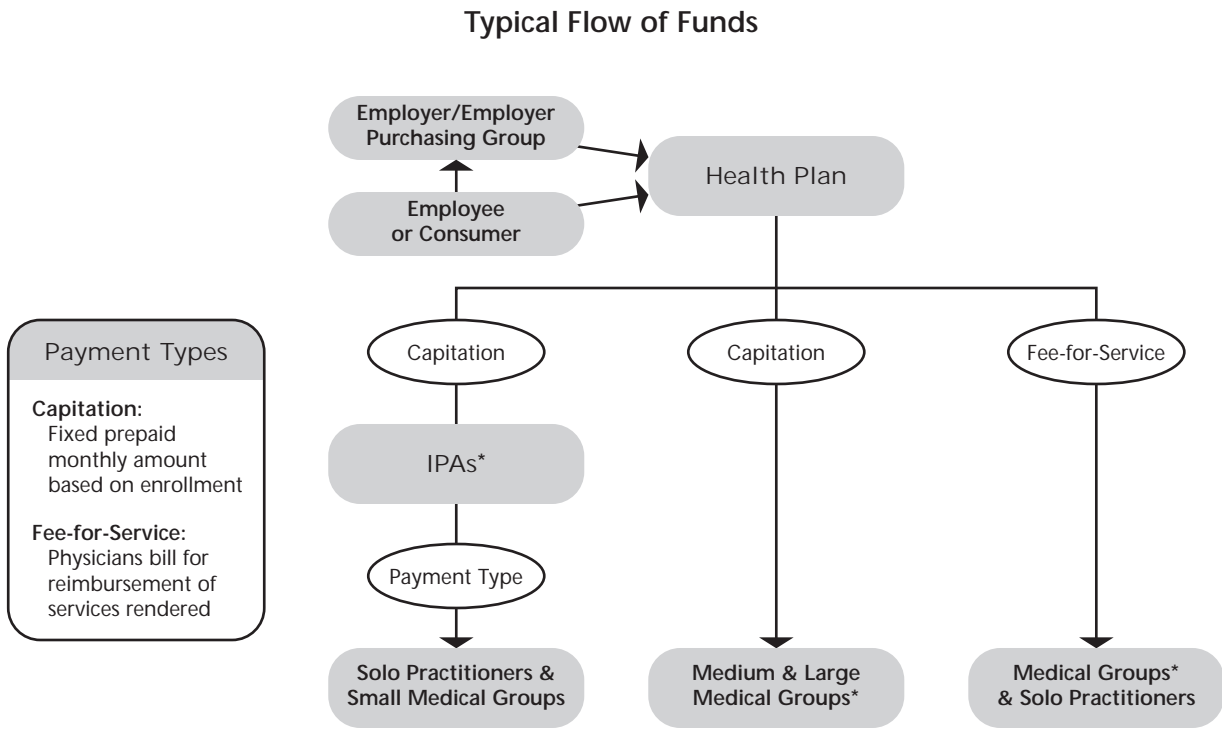
## OVERVIEW OF THE ENTITIES AND FLOW OF PAYMENTS IN THE HEALTH CARE INDUSTRY

Two main types of managed health care exist in California: health maintenance organizations (HMOs) and preferred provider organizations (PPOs). The more familiar of these two, the HMO, generally compensates physicians for their services by capitation payments—a predetermined fixed payment per member per month—made through intermediaries, either large medical groups or independent practice associations (IPAs). The intermediary organizations then pay their physicians either through sub-capitation or discounted fee-for-service. Often medical groups and IPAs take risk not only for covering their physicians' professional services, but to some degree for other medical services, such as hospital stays, pharmacy services, or

ambulance services. They assume this risk in one of two ways: through shared-risk pools with HMOs or by obtaining a limited license from the Department of Corporations, which allows them to take over full risk from HMOs in certain areas. The large medical groups and IPAs that assume full risk also pay claims to providers outside their organizations in addition to paying those within.

PPOs, on the other hand, contract directly with individual physicians and pay them using a discounted fee-for-service arrangement, which reimburses physicians at an agreed-upon rate, usually lower than physicians charge in their own practices, for each type of service. Unlike the HMO system, which periodically pays physicians a fixed prepaid amount per member, the physicians receive payments under a PPO system when they present claims for reimbursement of services rendered. However, although the PPO contracts directly with the physician, the payment often flows through to the physician's medical group, regardless of size. Figure 1 illustrates the general flow of payments under a capitation system, typically associated with HMOs, and under a fee-for-service system such as PPOs use.

FIGURE 1



\* In those instances in which management services organizations (MSOs) provide administrative services for medical groups or IPAs, the health plan could send the payment through the MSO.

Other types of intermediaries, physician practice management companies and foundations, may own the assets of medical groups or IPAs. Still, other medical groups or IPAs may contract with management services organizations to provide administrative services. The following sections provide more detailed information on these entities and the types of payments.

## TWO PAYMENT TYPES ARE COMMON

The managed health care industry pays the providers of medical services in two basic ways—capitation and discounted fee-for-service. In 1997, 86 percent of the commercial HMOs in California reported that they paid medical groups and IPAs on a capitated basis for primary care services and 77 percent reported they also made capitation payments to medical groups and IPAs for specialists.<sup>1</sup>

Capitation consists of a predetermined fixed payment per member per month for which the provider agrees to supply a defined set of medical services for a certain period of time, usually one year. Whether a consumer uses the health service once or a dozen times during this period, a provider receives the same payment.

Many providers, however, are paid under what is called shared-risk capitation. Under shared-risk capitation, the provider through their medical group or IPA receives payments only for professional services but also participates in a risk pool with the health plan for other types of medical services, such as hospital stays or pharmacy costs. The health plan, in essence, deposits an amount into a separate account to cover the costs of these other medical services. As the provider orders these specific services for a consumer covered by the health plan, the health plan pays for them out of the risk pool.

Other providers assume full risk through their medical groups or IPAs for all professional and institutional services to eligible patients. Before a provider organization can accept full-risk capitation, however, it must be licensed by the Department of Corporations. Provider organizations often purchase stop-loss insurance, which limits their financial liability per episode of

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<sup>1</sup> Schauffler, H.S. and Brown, E.R. *The State of Health Insurance in California, 1998*, Regents of the University of California, 1999, page 62.

illness or per year for any individual patient, and thus limits their overall financial risk even in shared- or full-risk contracts.

For discounted fee-for-service payments, the provider and the health plan enter into a contract specifying the amount to be paid for every service covered by the health plan. After a provider renders medical services to a consumer, he or she submits a claim for the cost of the service to the appropriate health plan. Under this arrangement, providers are not limited to the number of claims they can submit to a health plan. This payment type is called discounted fee-for-service because the agreed-upon rates are usually not the full amount of the rates set by providers for their own practice.

## **MANAGED HEALTH CARE HAS SEVERAL ENTITIES IN THE PAYMENT FLOW**

Consumers of health care services will most likely know the name of their physician, or provider, and the health care plan they pay premiums to (or to which their employers contribute on their behalf). Consumers typically are not aware of other entities that have a hand in their health care. These entities do not directly provide medical services, but they help distribute health care premium dollars and control, or manage, costs. These intermediary organizations (so-called because they are between the physician and the health plans) are IPAs, physician practice management companies (PPMCs), and management services organizations (MSOs). Some medical groups contract directly with health plans, rather than work through IPAs; these groups, which are usually large, also function as intermediary organizations when they contract and pay for services from physicians and other providers of medical services outside their own organizations.

### **Health Plans**

Health plans constitute a group of entities within the health care industry. Health plans market their various lines of business to individual consumers, employers, and employer purchasing groups. They also arrange through contracts to have a sufficient selection of physicians available in the geographic regions they serve to provide medical care to consumers.

Managed care encompasses a variety of health plans. One of the more widely known is the HMO. Although all HMOs are

managed care plans, not all managed care plans are HMOs. Also included under managed care are point of service (POS) plans and PPOs, which include exclusive provider organizations (EPOs). By 1997, 58 percent of California's insured population under 65 years of age was enrolled in HMO plans, with another 24 percent enrolled in PPOs and EPO plans. The portion of workers enrolled in POS plans was 6 percent, with the remaining 2 percent covered by indemnity insurance plans.<sup>2</sup>

An HMO limits consumers' choice of physicians and physicians' choice of referrals to specialists. Consumers must use contracting HMO providers and adhere to the plan's referral and authorization rules to have their health care costs covered. POS plans

operate much like HMOs, except consumers can choose any physician for health care services. The plan covers more of the costs of services provided by plan physicians than by nonplan physicians. Consumers make the decision about which physician to see when a service is needed, at the point of service, hence the name of the plan. Consumers can choose a different physician each time they need medical care. PPOs also allow consumers to choose outside physicians but provide a number of financial incentives to encourage use of physicians they have contracted with.

Indemnity plans are simply health insurance policies. A consumer purchases the policy and may choose any provider for medical services. After the service is rendered, the insurance company pays the provider based on their fee structure. The consumer pays any deductible, coinsurance, and copayment amounts for any services not covered by the insurance policy.

In 1997, 58 percent of all Californians less than 65 years of age were covered by some form of health insurance through their own or a family member's employment. Another 5 percent purchased their own health insurance. Of Californians who received health care coverage through their employers, 70 percent were members of HMOs and 22 percent were members of PPOs. The major

### Health Plans

**Health Maintenance Organizations (HMOs)**—form of managed care that can pay a set monthly amount per person enrolled (capitation payments) or discounted fee-for-service. Also, under the HMO environment, consumers choose a primary care physician from a list of those that contract with the HMO; referrals to specialists are limited to those identified and stipulated by the HMO.

**Point of Service (POS) Plans**—combines HMO features and out-of-network coverage with economic incentives for using network providers.

**Preferred Provider Organizations (PPOs)**—pays on a fee-for-service basis. They offer financial incentives to beneficiaries who obtain medical care from a preset list of physicians and hospitals.

**Exclusive Provider Organizations (EPOs)**—organized similarly to a PPO in that physicians do not receive capitation payments. However, an EPO only allows beneficiaries to choose medical care from network providers. If the beneficiary elects to seek care outside of the network, the EPO will not reimburse the beneficiary for the cost of the treatment.

**Managed Indemnity Plans**—pays on a fee-for-service basis only. These are simply health insurance policies.

<sup>2</sup> Schauffler, H.S. and Brown, E.R. *The State of Health Insurance in California, 1998*, Regents of the University of California, 1999, page 48.

companies offer other forms of health care coverage, as well, such as indemnity health insurance and POS plans.

### Physicians and Medical Groups

A physician operates either in solo practice or as part of a medical group. Medical groups range in size from 2 or 3 to over 100 physicians and may consist of only primary care physicians or specialty care physicians, or be a multi-specialty medical group. Large medical groups often have a sufficient consumer base and enough physicians with a range of specialties to make it economically feasible for them to directly contract with health plans for capitated contracts. These large medical groups function as an intermediary organization in relation to any contracts for medical services with physicians and institutional providers outside the medical group's own organization.

A large consumer base is needed in a capitated contract to increase the likelihood that the practice will have enough fees to allow its healthy consumers to balance the costs of medical care for its less-healthy consumers. The number of physicians and their specialties are also important in a capitated contract, affecting whether the medical group contracts with physicians outside the group to provide the services its consumers need.

#### Providers

**Physicians**—providers of medical services. Physicians are either in solo practice or part of a medical group.

**Medical Groups**—a group of physicians that share facilities, records, and personnel and are considered a legal entity.

### Independent Practice Associations

IPAs have much in common with large medical groups. Whereas physicians in large medical groups are in a position to contract directly with health plans for capitated payments, solo practitioners and small- to medium-sized medical groups usually are not. For this reason, IPAs have been established. The IPAs contract with health plans and receive the capitation payments. To provide medical services to the consumers covered by the capitated plans, the IPAs contract with physicians, who are either solo practitioners or who practice in small- to medium-sized medical groups. Physicians may contract with more than one IPA. The IPAs pay their own costs and affiliated physicians from the capitation payment. An IPA may pay its affiliated physicians on either a capitated or discounted fee-for-service basis. Like a large medical group that contracts directly with an HMO, an IPA may also participate in risk pools with health plans and may share its portion of the risk pool distribution or

loss with its affiliated physicians. The benefit of an IPA to a physician is access to a larger pool of potential patients. The benefit of an IPA to the health plan is a wider selection of physicians for the consumer to choose from, which is an incentive for the consumer to choose that health plan.

### Physician Practice Management Companies, Medical Foundations, and Management Services Organizations

Both PPMCs and medical foundations may provide management services to a medical group, but PPMCs are privately held, for-profit companies, whereas medical foundations are nonprofit organizations established by hospitals. PPMCs became significant entities in the managed

health care field during the mid-1990s, but their presence appears to be waning. PPMCs purchase the assets of medical groups and IPAs, bringing an infusion of cash to medical groups that need to buy out members nearing retirement or groups that need to purchase information systems to accumulate the information needed for managing the costs of health care.

Since PPMCs cannot directly own the assets of medical groups (due to the prohibition under California law against the corporate practice of medicine), these organizations work through entities called MSOs. The MSOs manage the medical groups and IPAs owned by the PPMCs and others that contract with the MSO for administrative services. The MSO acts as an agent for the medical groups and IPAs, receiving money owed to them and distributing the money as determined by its contractual agreements.

#### Intermediary Organizations

*Independent Practice Associations (IPAs)*—contract with solo practitioners and small medical groups and in turn, contract directly with health plans on their behalf.

*Physician Practice Management Companies (PPMCs)*—purchase the assets of medical groups and IPAs for infusion of cash. These entities work through MSOs.

*Management Services Organizations (MSOs)*—manage the medical groups or IPAs owned by the PPMCs as well as others that contract with the MSO for administrative services. The MSO acts as an agent for the medical groups and IPAs, receiving money owed to them and distributing the money as determined by its contractual agreements.

Each of the entities described above plays a critical role in managed care, and we have solicited their perceptions through our survey. We have structured our report to discuss the results of the surveys of physicians and medical groups in Chapter 1 and the results of the health plan and intermediary organization surveys in Chapter 2. This structure allows us to discuss the results from the perspectives of the providers of medical services

and the payers for those medical services. Recognizing that some of the large medical groups can also function as intermediary organizations, we have included results specific to those groups in Chapter 2, as applicable.

## THE REGULATORY STRUCTURE OVER HEALTH CARE IS COMPLEX

Mirroring the complexity of the health care environment, the regulatory structure over the health care industry includes a number of state and federal agencies. Certain elements of the industry may have to follow the regulations of several agencies, while others may have virtually no regulatory oversight.

At the state level, the Insurance Code and the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), which is included in the Health and Safety Code, are the two primary bodies of law authorizing state regulation of health care plans. The Insurance Code, enforced by the Department of Insurance, establishes the regulations applicable to the relatively small number of indemnity health plans and to certain PPOs. Among its provisions are requirements to license indemnity plans operating in California and monitor their financial stability. The Knox-Keene Act applies to HMOs, POS plans, and some PPOs, and establishes the Department of Corporations as the regulatory agency for these plans. It contains extensive requirements for the licensing of plans, consumer protection, grievance procedures, and monitoring the financial stability of the plans.

In addition to the Departments of Insurance and Corporations, the Department of Health Services regulates health care plans that provide services to Medi-Cal beneficiaries, and the Department of Industrial Relations regulates workers' compensation plans.

Moreover, the Medical Board of California, the Department of Health Services, and the Office of Statewide Health Planning and Development oversee the provision of medical services by physicians and health care facilities, such as hospitals and clinics. No state agency, however, oversees other entities, such as intermediaries, in the health care industry.



## SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee asked the Bureau of State Audits to survey physicians, health maintenance organizations, and insurance companies to assess the impact of delayed payments to physicians on the cost of health care in California. To understand the health care industry and environment in California in general, and to determine the roles, responsibilities, processes, and procedures relevant to the approval and payment of claims for health care services rendered, we reviewed professional literature on the subject. We also interviewed executives of organizations representing physicians and health plans; representatives of one of the large health plans operating in the State; administrators with the Department of Corporations, which has responsibility for overseeing certain segments of the health care industry; and administrators with the Department of Insurance, which has certain oversight and licensing responsibilities for health plans operating in California. In addition, we reviewed applicable laws, rules, and regulations. To assist us in this work, we used the services of consultants who are experts in the health care field.

We used the information gathered from all these sources in preparing survey questionnaires. We also subjected each of the questionnaires to pretesting by representatives of the survey population, whom we asked to assess them for the clarity and objectivity of questions, availability of information requested, appropriateness and completeness of response choices, clarity of instructions, necessity for making any assumptions in responding to our questions, and clarity and convenience of the formats. In addition, we asked pretesters to describe any other concerns or questions that we should be addressing. We assessed the responses from the pretesters and made any necessary changes to the questionnaires before distributing them to the survey participants. Respondents, other than health plans, had the opportunity to complete the questionnaires in either hard copy or electronic form. We also asked respondents to make any additional comments they believed to be relevant. Further, we asked respondents if they would be able to provide documentation to us for late payments or tracking of payments.

During the course of our inquiries, we determined that intermediary organizations, including medical groups, independent practice associations, management services organizations, hospital-based foundations, and physician practice management companies, played critical roles in the adjudication and payment of physician claims and capitations. We therefore surveyed these entities, as well as physicians, health maintenance organizations, and insurance companies. Appendix B provides detailed information about how we identified members of the survey populations and selected those to survey.

In compiling, analyzing, and interpreting the results of the surveys, we again used the services of consultants who are specialists in the field. We assessed the results of the five surveys individually and in combination to first determine what perspectives each group had on the survey issue, then what differences in perspectives existed, and, if possible, the reasons for and extent of these differences. We performed no independent tests of the accuracy of the information provided to us in the surveys. ■

# CHAPTER 1

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## *Some Physicians and Medical Groups Have Concerns About Delayed Payments*

### CHAPTER SUMMARY

**W**e surveyed 1,300 California physicians and 1,025 medical groups to determine the extent to which they believe they receive late or inaccurate payments for their services and the effect any delays may have on their practices. We received 462 responses we could use from physicians and 130 from medical groups. Approximately half the physicians and most of the medical groups responding to our survey had concerns about delays in payments. Fee-for-service payments from independent practice associations (IPAs), preferred provider organizations (PPOs), and point of service (POS) plans were frequently cited as areas for delays. Late capitation payments were less frequent; however, one-third of medical groups reported problems with the accuracy of enrollment lists that are the basis for capitation payments. Finally, most medical groups reported that health maintenance organizations (HMOs) and other health plans do not pay interest on delayed payments.

When we asked what impact delayed payments have on their practices, 129 of 462 physicians and 49 of 130 medical groups reported that delayed payments have negatively impacted the business aspects of their practices by creating cash-flow problems, increasing overhead costs, or causing other problems. However, only a small number in these groups reported that delayed payments have an impact on service delivery and patient care. We discuss the perspectives of health care payers on these same issues in Chapter 2.

### SURVEY RESULTS INDICATE CERTAIN PROBLEMS WITH PAYMENTS

In this chapter we discuss the perspectives of providers of medical services—physicians and medical groups—about the extent to which they receive delayed or inaccurate payments and the

resulting impact they report on their practices. In general, those providers reporting problems expressed concerns of varying degrees about delayed fee-for-service payments from both intermediaries and health plans. Problems they reported with inaccuracies in payments tended to focus on the insufficiency of the information they received about payments from the payers. Since their responses are affected by their particular experiences and the nature of their practices, we describe these influences when we are able to identify them.

To gain their perspective, we surveyed a random sample of 1,300 of California's 74,104 licensed physicians. Of the 783 responses we received, 462 of the respondents indicated they provide medical services, and we analyzed these surveys. The physician survey measures respondents' observations on the frequency of delayed payments, captures physicians' opinions about which entities cause delayed payments, and assesses the impact of delayed payments on service delivery. In addition, we sent surveys to 1,025 California medical groups to determine if these groups experience payment delays and inaccuracies. We received 130 completed surveys that we used for our analysis. The questions we asked on both surveys appear in Appendix C.

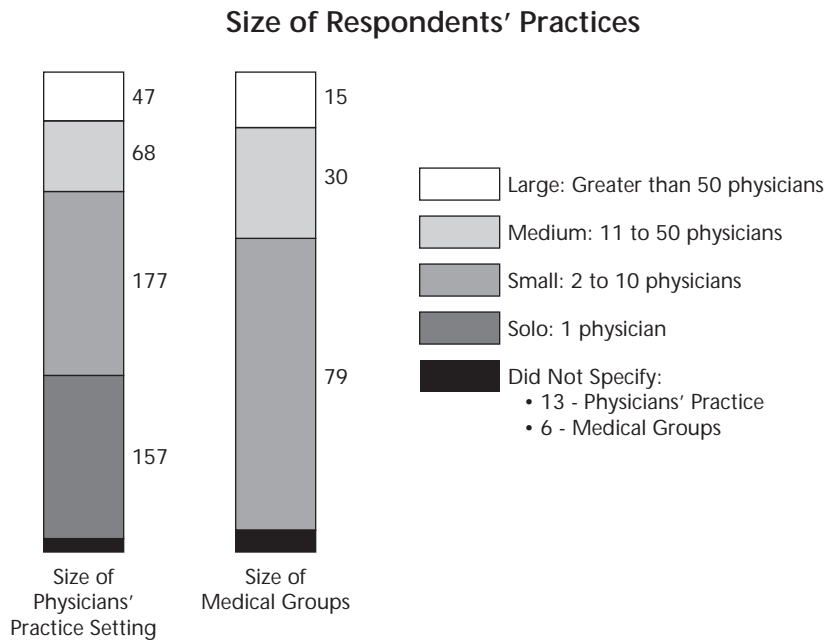
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*A high percentage of the 462 physicians responding to our survey are solo practitioners or work in small medical groups.*

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As shown in Figure 2, a high percentage of the 462 physicians responding to our survey are solo practitioners or work in small medical groups. Of these physicians, 244 are paid salaries in their main practices, and are therefore less likely to have as much experience with fee-for-service payments as the 208 nonsalaried physicians in the survey. In fact, the nonsalaried physicians in our survey receive 85 percent of their compensation from their main practice through fee-for-service payments and the remaining 15 percent through capitation. As Figure 2 shows, most of the 130 medical groups responding to our survey are small- and medium-sized and are, therefore, likely to contract with IPAs rather than directly with health care plans. Only 30 of 130 groups report that they contract with physicians outside their group. For a more detailed profile of physicians and medical groups responding to our survey, please see Appendix B.

**FIGURE 2**



Between 21 percent and 34 percent of the physicians gave no opinion on various questions posed about delayed payments. For the most part, we found that as the size of the physicians' medical group increased, the more likely the physicians were to give a "no opinion" response. Based on physicians' comments, the lack of expressed opinions may be attributed to physicians who indicated they have limited direct knowledge about the business aspects of their practices. In fact, some explained that they contract with external groups to handle billing. In contrast, medical groups are more likely to be directly involved in the payment process, enabling them to answer more detailed questions about delayed payments. In fact, we generally found that on the medical group survey a greater percentage answered questions about payment delays.

The responses from physicians and medical groups have value in their own right, but it is also important to consider the perspectives and experiences of other entities, such as IPAs, health care plans, and management services organizations (MSOs). Chapter 2 presents their responses to questions about payments. Some responses parallel those of the physicians and medical groups and some do not.

## ONE-HALF OF THE PHYSICIANS AND MOST MEDICAL GROUPS EXPERIENCE SOME DELAYED PAYMENTS

About 51 percent (236 of 462) of physicians and almost 74 percent (96 of 130) of medical groups stated they experience some form of delayed payment from health care payers for whom they provide services. Because these providers contract or have other service agreements with a variety of health care payers, we asked them to specify the kind of organization paying late and the type of payment made. While late HMO and IPA capitation payments and medical groups delaying reimbursement for services rendered were mentioned, fee-for-service claims were most frequently cited. In addition, most medical groups reported the HMOs and other health care plans do not pay interest on delayed payments.

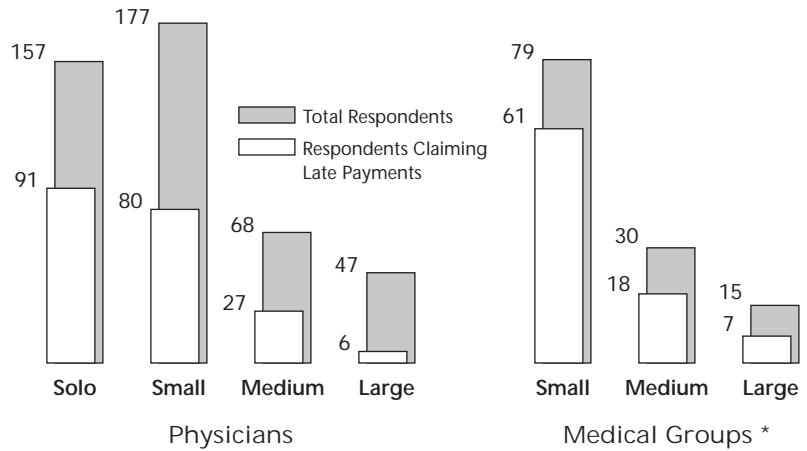
### Late Payments of Fee-for-Service Claims by IPAs Are Problematic

Based on the results of our survey, many physicians and medical groups have problems with IPAs payment of fee-for-service claims. Of the 130 medical groups in our survey, 103 contracted with IPAs, and 86 of these reported delayed fee-for-service payments from IPAs. Further, of the 462 physicians responding to our survey, 204 indicated having experienced delayed fee-for-services payments from IPAs and an additional 39 said they had not. The remaining 219 responses were a combination of “not applicable” and “no opinion” responses, among which we were unable to confidently distinguish how many contract with IPAs. As we noted earlier, however, many of the physicians who provided “no opinion” responses often have limited direct knowledge about the business aspects of their practices.

As shown in Figure 3, solo practitioners and small- and medium-sized medical groups were most likely to have these concerns. Figure 3 also shows that, unlike the physician responses, the proportion of medical groups reporting this problem varies little as the size of the group increases.

**FIGURE 3**

**Late Fee-for-Service Payments From IPAs**



\* Six medical groups did not specify size.

Half of the 204 physicians who have experienced late fee-for-service claims payments indicated they experienced delayed payments often, and another 40 percent said it happened sometimes. Moreover, 64 percent of the 86 medical groups that reported late claims payments said that IPAs often delayed fee-for-service claims payments.

The profile of physicians responding to our survey appears consistent with recent literature on the health care industry. Solo practitioners and physicians in small- and medium-sized medical groups often contract directly with IPAs to increase their access to HMOs. Large medical groups, on the other hand, are more likely to directly contract with the health plans and bypass IPAs. Thus, the number of negative perceptions about late payments received from IPAs may in part be a function of the large percentage of payments made by IPAs to our responding physicians. On the other hand, the impact of the small- and medium-sized medical groups on the survey results could be balanced by primary care physicians who are paid by capitation from the IPAs.

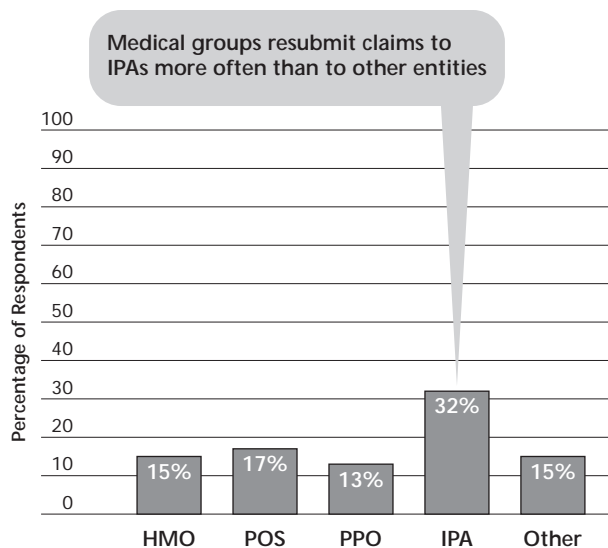
Physicians in large medical groups could have been another factor affecting the results of the physicians survey. They may not have reported late fee-for-service payments because they are salaried, insulated from the accounting aspects of the practice, and therefore less likely to know about payment delays. Finally, the nature of fee-for-service payments lends itself to some justifiable delays if the IPA has questions about the service provided or finds inconsistencies between the claim and the provisions of its contract with the provider.

### Medical Groups Resubmit Claims Most Often to IPAs

When asked how frequently they have to resubmit claims to health care plans and other entities, as Figure 4 shows, 32 percent of the medical groups who responded, reported that they always or usually had to resubmit claims to IPAs, more than twice the average for other payers. Once again, the focus on IPAs could be affected by the large number of small- and medium-sized medical groups that responded. Nevertheless, resubmitting claims could be a contributing factor to the perception that IPAs are the source of payment problems.

FIGURE 4

Frequency of Medical Groups' Resubmission of Claims





### Some Providers Also Reported Problems With Delayed Capitation Payments

Because capitation payments are established by a contract and are routine, fixed payments per health plan member for each period, we expected to find little to no problem with late payment. In fact, some physicians and medical groups report that they do not receive these payments on a timely basis. Both physicians and medical groups responded they are more likely to receive delayed capitation payments from HMOs than from IPAs. Of the 462 physicians responding to our survey, 116 (38 percent) reported that HMOs do not pay capitation payments by the dates specified in their contractual agreements. A majority of those, 80 physicians, indicated their capitation payments are often late. An additional 265 responses were a combination of “not applicable” and “no opinion” responses. Similarly, 21 percent (27 of 130) of the medical groups indicated that HMOs pay late. Of the 44 medical groups who gave no answer to this question, 37 were small- or medium-sized and, therefore, less likely to contract directly with HMOs.

The number of physicians reporting late capitation payments from HMOs, 116, is somewhat smaller than the number reporting problems with IPA fee-for-service payments, 204. However, in narrative comments, five physicians reported that they have withdrawn from contracting with HMOs because of adverse experiences. A few physicians stated they have stopped contracting with IPAs and other health care plans, as well.

### Other Health Plans Can Be Slow In Paying Claims

PPOs and POS plans provide 20 percent and 6 percent, respectively, of the gross revenue of the medical groups responding to our survey. We asked the medical groups to provide an average number of days for them to receive payment after billing uncontested claims to their top three PPOs and POS plans, defined in terms of revenue. Both types of health plans came in for some criticism, but the POS plans, the less commonly used of the two, received more negative responses. Of the 130 medical groups responding to our survey, 73 reported on at least one POS plan. Of the 187 total responses about POS plans, 69 indicated medical groups received payment within 45 days and 118 reported payments took longer. More medical groups, 87, responded to questions about how promptly PPOs paid

uncontested claims. Of the 246 responses about PPOs, medical groups reported an even division between those payments made within 45 days or after 45 days.

### Some Physicians Receive Late Payments From Medical Groups With Which They Contract

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*Thirty-eight percent of physicians contracting with medical groups reported delayed payments.*

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In addition to receiving payments directly from health plans and IPAs, physicians can contract with medical groups to provide specific professional services. In this instance, the medical groups act as intermediary organizations in contracting with and paying claims to physicians outside their group. Of the 462 physicians responding to our survey, 115 indicated that the medical groups with which they contract delayed payment. A majority of those, 66 physicians, reported that this occurs frequently. An additional 254 responses were a combination of “not applicable” and “no opinion” responses.

### Most Medical Groups Receive No Interest on Late Payments

We asked medical groups if commercial HMOs and other health care plans pay interest to them on delayed payments; most responded negatively. Of the 130 medical groups responding to our survey, 78 percent indicated that HMOs rarely or never pay interest and 75 percent said that health plans other than HMOs, such as PPOs, rarely or never pay interest. HMOs are statutorily required to pay interest on uncontested claims not paid within 45 days, and health care service plans, other than HMOs, must add interest to uncontested claims not paid within 30 days. As discussed in Chapter 2, the medical groups’ experiences with HMOs not paying interest was similar to that reported by the MSOs, although the MSOs reported less of a problem with the health plans other than HMOs. However, from the survey responses, we cannot determine whether these claims are uncontested or if there are other factors that caused the payments to be delayed.

### SOME MEDICAL GROUPS REPORT RECEIVING INACCURATE PAYMENTS

We also asked medical groups about the accuracy of some of the payments they receive, and they indicated problems with the accuracy of the enrollment lists that support capitation payments and with IPAs paying claims at lower than contracted amounts.

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*Only 9 percent of medical groups reported that HMOs make inaccurate capitation payments; however, more cited errors in enrollment lists.*

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Of the 130 medical groups, 53 (41 percent) responded that the capitation payments they received were always or usually accurate. Only 11 of 130 medical groups (9 percent) reported that HMOs make inaccurate capitation payments. However, when asked about the accuracy of enrollment lists, 51 (39 percent) reported problems in receiving accurate lists from health care plans. In addition, some medical groups reported that IPAs pay fee-for-service claims at a lower amount than the contract rate.

### **Outdated Enrollment Lists Can Cause Inaccurate HMO Capitation Payments**

We asked medical groups if the capitation payments they received from commercial HMOs were accurately computed. Although only a small number of medical groups said they experience capitation payment inaccuracies, their comments reveal frustration with the accuracy of the enrollment lists, their ability to independently verify population numbers, and computation errors. Similarly, as discussed in Chapter 2, MSOs and IPAs also expressed concerns with the accuracy of enrollment lists.

Of the 130 medical groups responding, 51 reported receiving inaccurate enrollment lists from health plans. We asked medical groups to describe the errors in the enrollment lists and 38 reported that the eligibility information provided by the plans is outdated or incorrect. For example, one medical group stated that changes to eligibility dates are usually 30 to 60 days late and others reported errors in patient names and other demographic data. Eight medical groups stated that health care plans do not provide enrollment lists, which results in the medical group not having a reliable way to verify the number of eligible patients and determine if capitation payments are correct. Several medical groups also stated they had experienced problems with retroactive adjustments to enrollment lists.

### **Sometimes IPAs Pay Fee-for-Service Claims at a Lower Amount Than Billed**

Another concern that medical groups reported was with payments that were lower than the contracted amount for the services rendered. Of the 130 medical groups responding to our survey, 103 contract through IPAs, and 66 (or 64 percent) of those experience IPAs paying fee-for-service claims at a lower amount than the contracted rate. Medical groups report that the

most frequent reason IPAs give for paying a lower amount is that the IPA combines service codes differently than the medical group bills them. Although we did not ask how often claims are paid at a lower amount, the number of medical groups that indicated experiencing lower payments contradicts IPAs' responses. This is in direct contrast to the view of IPAs and MSOs who report that they pay 1 percent to 24 percent of claims at a lower rate than contracted, as discussed in Chapter 2.

### A FEW PHYSICIANS REPORT INACCURACIES IN RISK POOL PAYMENTS

We asked physicians about the accuracy of risk pool distributions they received, and many indicated the questions were not applicable or they had no opinion. Of the 462 physicians responding, 79, or 17 percent, believed that HMOs make inaccurate payments of risk pool surpluses. Additionally, 16 percent (74 of the 462) reported that IPAs made inaccurate risk pool distributions.

#### Risk Pool

In a capitation payment environment, a health plan sets aside an agreed-upon per member per month amount in a risk pool that is used to cover designated medical services, usually hospital or pharmacy services, that the physician organization is not then responsible for paying. The health plan pays for these services and divides any money left in the pool with the physician organization. If there is a shortfall in risk pool funds, the health plan and physician organization share the liability.

When asked to describe the payment inaccuracies, 23 physicians thought that problems with HMO risk pool payments stemmed from questionable calculations and 9 reported errors in enrollment data. In addition, several physicians expressed concerns about the lack of risk pool data provided by HMOs and IPAs and others admitted to not knowing what was inaccurate about these payments.

Some narrative responses also revealed that physicians and medical groups do not receive risk pool payments of any kind. Fifteen physicians reported they never receive risk pool surplus payments from IPAs and 10 reported never receiving payments of risk pool surpluses from HMOs because there is never a surplus. One physician commented that he rarely receives significant risk pool surpluses despite HMOs reminding him when he signs a contract that risk pool surpluses will make up for the lower capitation payments. We discuss risk pool payments in more detail in Chapter 2.

## SOME PROVIDERS RESPONDED THAT DELAYED PAYMENTS CAUSED CASH-FLOW PROBLEMS, BUT HAD LITTLE IMPACT ON PATIENT CARE

When we asked what impact delayed payments have on their practice, both physicians and medical groups had similar responses. Of the 462 physicians, 129 (28 percent) and 49 of 130 medical groups (38 percent) reported that delayed payments have negatively impacted the business aspects of their practices, such as creating cash-flow problems and increasing overhead costs.

Some of the physicians' and medical groups' written comments on cash-flow problems reveal frustration with the additional administrative burdens delayed payments cause. A few report that they have hired additional staff or require staff to work additional hours. Some physicians also reported that they have had to borrow money or rely on lines of credit in order to continue operations and pay their bills. Notably, a small number of physicians and medical groups reported that because of payment delays they have changed the way they conduct business. In particular, they no longer take HMO or PPO patients or have limited the number of certain types of patients, and some operate exclusively on a fee-for-service basis. Others have terminated contracts with slow payers or closed their office practices and affiliate with larger groups or hospitals.

While many physicians and medical groups described negative fiscal impacts, 46 physicians (10 percent) and 25 medical groups (19 percent) also commented that delayed payments had not impacted service delivery or patient care. Significantly fewer physicians (22) and medical groups (6) report that patient care has been negatively impacted by delayed payments. A small group of physicians expressed concerns about having to delay elective surgery, inability to supply durable medical goods, problems with sending patients to specialists, and needing to reduce special services to seriously ill patients. In addition, both physicians and medical groups report that they are reluctant to treat some patients, and one medical group reported that both time and money have shifted from patient care to administrative matters. ■

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## CHAPTER 2

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### *Health Care Payers Have Different Views and Report Little Difficulty With Payment Delays*

#### CHAPTER SUMMARY

**I**n general, the results of our surveys of health plans, management services organizations (MSOs)<sup>3</sup>, and independent practice associations (IPAs) showed that these entities believe they receive and make most payments within reasonable time frames. The results of these three surveys were more positive than the overall provider results discussed in Chapter 1. The IPAs reported relatively few problems in receiving payments from health plans and also reported making timely payment of capitation and fee-for-service claims to their providers, which was at odds with the results of the provider surveys. However, nearly half of the MSOs and IPAs responding indicated that they contested risk pool distributions from health maintenance organizations (HMOs) or point of service (POS) plans.

Although relatively few health plans, MSOs, and IPAs extensively use electronic claims and payment processes, their use could shorten the overall time for claims to be processed and payments made. Our survey also revealed that about 84 percent of both the MSOs and IPAs that responded had set up a complaint resolution process to handle physicians' complaints about payments. The MSOs and IPAs also reported a wide variation in how frequently their complaint resolution processes are used.

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<sup>3</sup> For the purposes of this report, we are using the term management services organization (MSO) to include physician practice management companies, hospital-based foundations, as well as actual management services organizations.

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*None of the health plans, MSOs, or IPAs that responded to our surveys directly provide medical services to Californians.*

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## BACKGROUND

None of the health plans, MSOs, or IPAs that responded to our surveys directly provide medical services to Californians. However, each has a role in the administration of managed health care and in the distribution of health care premiums. The responses in general were more positive and the narratives more moderate than the responses from the provider groups as discussed in Chapter 1, possibly because these payer organizations are closer to the source of the premiums and tend to have more control over the timing and processing of payments.

To determine their perspective on the extent and nature of delayed payments, we sent surveys to 301 IPAs that we identified from various sources, and received 51 responses that are the basis for our analysis later in the chapter. Similarly, we sent surveys to 139 MSOs that we identified, and received 13 that we use in our discussion. The limited number of responses to these surveys means it is not appropriate to generalize the results to the entire population; therefore, we do not. Our final survey was of the 7 largest commercial health care plans, excluding Kaiser Permanente, operating in California. Across all their product lines, these 7 plans have a total enrollment of over 12 million and cover almost half of the insured population in California. All 7 responded to our survey. Appendix B provides a discussion of our survey methodology and profiles of the survey respondents. Appendix C shows a list of our survey questions.

The numbers of health plans, MSOs, and IPAs that did not respond to specific questions varied with the question asked. The “no answer” responses may be attributed to transactions that do not apply to the respondent’s business situation. In some instances, the respondent may have chosen not to disclose the information, even if it did apply.

## PAYER GROUPS HAVE FEW PROBLEMS WITH TIMELY CAPITATION PAYMENTS

Survey responses from health plans, MSOs, and IPAs indicated no significant issues related to the timing of receiving or issuing capitation payments. However, the MSOs and IPAs showed concerns about the accuracy of the capitation computations as



they relate to the accuracy of the underlying enrollment lists. As noted in Chapter 1, medical groups also had concerns about the accuracy of the enrollment lists upon which capitation payments are based. In addition, providers reported experiencing a higher level of delayed capitation payments than that reported by MSOs and IPAs.

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*In general, intermediaries reported receiving timely capitation payments from HMOs.*

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In general, both MSOs and IPAs reported receiving timely capitation payments from HMOs during calendar year 1998. Specifically, 12 of 13 MSOs and 36 of 51 IPAs reported that they always or usually received these payments by the date in their contractual agreements. Similarly, 10 of 15 large medical groups and 16 of 18 medical groups with full-risk capitation contracts with HMOs also reported always or usually receiving capitation payments by the date in their contractual agreements. As discussed in Chapter 1, there are a number of factors that could cause this contrast with the overall results from provider groups related to the timeliness of capitation payments. As to the payment schedules, the HMOs state they predominantly make monthly capitation payments, with one plan paying capitation semimonthly.

The majority of the 21 narrative comments from both MSOs and IPAs, related to their experiences with capitation payments from HMOs, indicated that delays are relatively short and not necessarily habitual. Further, four respondents attributed some of these delays to computer system conversions or other computer problems at the health plan and to transitioning to a new agreement. The two most serious comments concerned frequent delays by the same health plans and a two-month period when a health plan withheld most capitation payments.

We also asked for input on the accuracy of capitation payments received. Although most MSOs and IPAs responded that the capitation payments they receive are usually accurate, some of their narrative comments, particularly concerning enrollment lists, were more negative. Specifically, 11 of 13 MSOs and 32 of 51 IPAs indicated that the mathematical calculations of the capitation payments they receive are always or usually accurate. In addition, 17 of 18 medical groups with full-risk capitation contracts with HMOs (94 percent) indicated the capitation payments they receive are always or usually correct. Only 1 MSO and 3 IPAs reported that the mathematical calculation was

typically inaccurate. Of the 31 MSO and IPA respondents who provided narrative comments about inaccurate payments, only 4 cited the health plans' using the wrong rates to compute the capitation. Another 22 of the comments related to problems involving incorrect enrollment lists and inadequate explanations for retroactive and other adjustments to the capitation payments.

### Enrollment List Accuracy Is An Issue

When our payer groups respondents reported problems with capitation payments, the typical problem was accuracy of the underlying enrollment list. The accuracy of capitation payments from HMOs and POS plans revolves around the timeliness of the updating and accuracy of the enrollment lists. Among other things, enrollment lists show which beneficiaries are covered by the plan, the types of benefits they are entitled to receive, the primary care physician each has selected, age and risk factors that are used to compute the capitation rate, information about dependents, and other demographic information about the beneficiaries. The health plans use the enrollment information on the list multiplied by the appropriate capitation rate to compute each payment.

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*Although only a few MSOs and IPAs experienced inaccurate enrollment lists, narrative comments cited some errors in enrollment data, listings, and termination information.*

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Six of the seven health plans reported that they update their internal HMO and POS enrollment lists on a daily basis and send updated enrollment lists each month to participating IPAs and medical groups or the MSOs that provide their administrative services. The seventh health plan updates its internal HMO and POS enrollment lists weekly and sends out the updated enrollment lists monthly. The results of the MSO and IPA surveys paralleled that of the health plans.

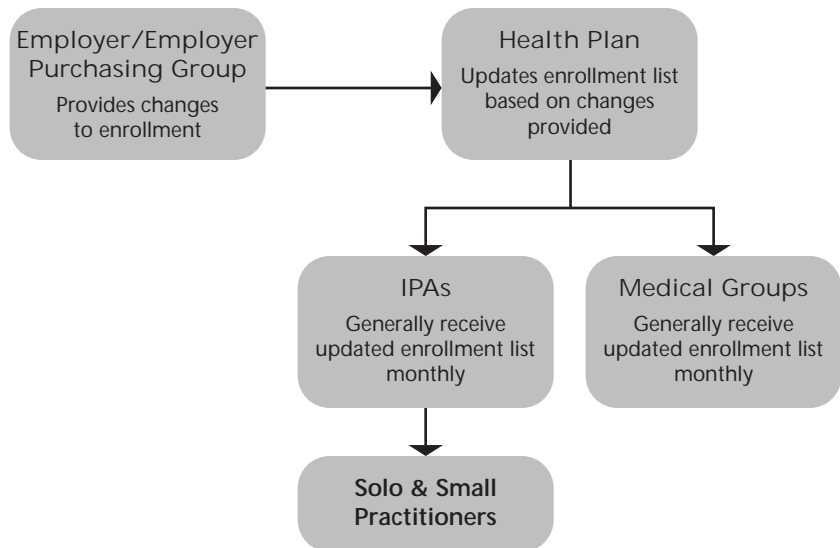
Although the numbers of MSOs and IPAs responding that they had experienced inaccurate enrollment lists in calendar year 1998 were relatively low, their narrative comments concerning enrollment lists expressed some lack of confidence in the enrollment information supporting the capitation payments. Moreover, these narrative comments are consistent with those made by medical groups, discussed in Chapter 1, concerning enrollment lists.

Although only 3 of 13 MSOs and 14 of 51 IPAs reported problems with receiving accurate enrollment lists from health care plans in calendar year 1998, narrative comments from 7 MSOs and 27 IPAs addressed the types of errors they encountered. They

cited enrollment data, listings, and termination information that are inaccurate, incomplete, or late. Additional comments from both MSOs and IPAs state that they find it difficult or impossible to reconcile the enrollment lists to the capitation lists because the effective dates on the two lists differ or they have no mechanism to verify the information. This is supported by responses from 3 of the 7 health plans who reported they do not send enrollment information at the same time as the capitation payment. As noted by one of the health plans, the time between sending the enrollment list and the capitation payment can be about two weeks. As Figure 5 indicates, enrollment data originates with the employer and is processed by the health plan before the information is available to the appropriate physician or medical group.

**FIGURE 5**

**Entities Involved in the Flow of Information for Enrollment Lists**



As discussed in Chapter 1, 51 of 130 medical groups reported having experienced inaccurate enrollment lists in calendar year 1998. The narrative comments from the medical groups also cited inaccurate enrollment information and the inability of the medical group to reconcile the data on the list.

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*Some respondents commented about difficulties with retroactive adjustments to enrollment lists.*

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In addition, 10 of the narrative comments from MSOs and IPAs and 11 from medical groups addressed retroactive adjustments to the enrollment lists as a specific problem. While the comments do not quantify the magnitude or the timing of the retroactive adjustments, we find it notable that our respondents raised this as a distinct element of the problems they have with enrollment lists. Since retroactive adjustments could affect the capitation payment paid by the health plan, it is understandable that the entities being paid would want a relatively short, well-defined period during which the health plans could make retroactive adjustments. In fact, one of the health plans acknowledged that many of the organizations it pays would like it to adhere to a 90-day adjustment period. However, the health plan noted its difficulty to do this when its contracts with employers or employer purchasing groups allow a 36-month adjustment period. For example, some capitation payments to MSOs, IPAs, or medical groups could be reduced up to three years after the health plan originally paid for an enrollee, if an employer group notifies the health plan of the termination within its 36-month adjustment period.

### **ALL THREE TYPES OF RESPONDENTS REPORTED FEW PROBLEMS WITH FEE-FOR-SERVICE CLAIMS**

Most health plans indicated that they pay claims promptly. The seven health plans reported a similar range of an average number of days to pay claims for commercial HMOs, POS plans, and PPOs. The average ranged from 8 days to 92 days for all three types of plans. Moreover, five of the seven health plans reported an average of less than 45 days. This range was consistent with the survey responses from 3 of the 5 MSOs that file claims with health plans and track the length of time it takes for their claims to be paid. They reported that nearly two-thirds of the fee-for-service payments they received from health plans were paid within 45 days.

However, some concerns with fee-for-service payments surfaced. Seven MSOs responded to our question about whether they had received delayed fee-for-service payments. Of these, four reported delayed fee-for-service claims payments from health plans, with two indicating this happened usually and two indicating it happened sometimes. In addition, of the nine MSOs

reporting, two indicated that commercial HMOs usually include interest on late payments, with the remaining seven reporting they never receive interest on late payments from these HMOs. Four of eight MSOs responding to the question indicated that health plans other than HMOs never include interest on late payments, and the remaining four reported the health plans sometimes or usually included interest. As discussed in Chapter 1, 101 of the 130 medical groups indicated they rarely or never receive interest on delayed payments from HMOs, and 97 of 130 reported a similar problem with health plans other than HMOs.

As intermediaries in the health payment process, MSOs, IPAs, and the larger medical groups themselves pay fee-for-service claims to the physician groups they contract with. For example, to the question of how they paid their specialty care physicians, 44 of 51 IPAs indicated that 71 percent of their payments to specialists were made through a discounted fee-for-service process.

In addition, 8 of 13 MSOs (62 percent) and 33 of 51 IPAs (65 percent) reported an average number of days to pay uncontested claims of less than 45 days. An additional 3 MSOs and 8 IPAs pay claims between 45 and 60 days, with another 2 IPAs reporting more than 60 days to pay claims. Further, of the 6 large medical groups that pay physicians outside their medical groups, 4 of them reported paying claims within 45 days. As discussed in Chapter 1, the physicians and medical groups had many negative responses about slow capitation and fee-for-service payments from IPAs and delayed payments from medical groups. Thus, this is at odds with the results for the IPAs in our survey.

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*Most payers indicated they pay uncontested claims within 45 days.*

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Further, both the MSOs and IPAs reported that they pay only a small proportion of claims at lower than the contracted rate, also known as downcoding. Specifically, 2 of 13 MSOs and 14 of 51 IPAs reported they had paid any claims at less than the contract amount and all of them indicated it was between 1 percent and 24 percent of the total claims they had processed. As discussed in Chapter 1, over 60 percent of the medical groups that contract through IPAs reported they had experienced IPA's downcoding claims the medical groups had submitted for payment.

## HMOs, POS PLANS, AND IPAs MAKE RISK POOL DISTRIBUTIONS

In our surveys, we asked questions about HMOs' and POS plans' risk pool distributions to MSOs, IPAs, and medical groups, as well as distributions made by IPAs to their affiliated physicians and medical groups. In general, the responses about timing were positive, but the responses indicated concern over the accuracy of the distributions. Most MSO and IPA respondents reported receiving, on average, over 70 percent of risk pool distributions within 9 months of the close of the applicable risk pool year from both HMOs and POS plans. Although nearly half of the IPA respondents with risk pools with HMOs or POS plans did not

contest any of the distributions, 42 percent of the IPAs contested some part of their HMO risk pool distributions. In addition, 6 of the 8 MSOs that manage IPAs or medical groups participating in risk pools with POS plans contested the distributions.

Over half of the IPAs participating in risk pools with HMOs and POS plans reported making risk pool distributions to their affiliated physicians and medical groups and reported providing limited information about the transactions against the risk pools to them. This is consistent with the responses from medical groups about the risk pool distributions they receive from IPAs.

### Risk Pool

In a capitation payment environment, a health plan sets aside an agreed-upon per member per month amount in a risk pool that is used to cover designated medical services, usually hospital or pharmacy services, that the physician organization is not then responsible for paying. The health plan pays for these services and divides any money left in the pool with the physician organization. If there is a shortfall in risk pool funds, the health plan and physician organization share the liability.

### Timing of Risk Pool Distributions From Health Plans Seems Reasonable, But a Few Intermediaries Are Contesting At Least a Portion of Them

Risk pools are unique elements of shared-risk contracts that many HMOs and POS plans have with IPAs and medical groups. Under these contracts, the health plan divides the capitation related to assigned members into a share it pays directly to the IPA or medical group for professional services and a share it places into a risk pool to pay for designated services, such as hospital stays or pharmacy services. As these services are used by the assigned members, the health plan pays for the services out of the risk pool, with any surplus or liability shared at the end of the year with the IPA or medical group. Each year the amount of the risk pool and the capitation rate are premised on estimated usage of the pool and predetermined target goals. In essence, the

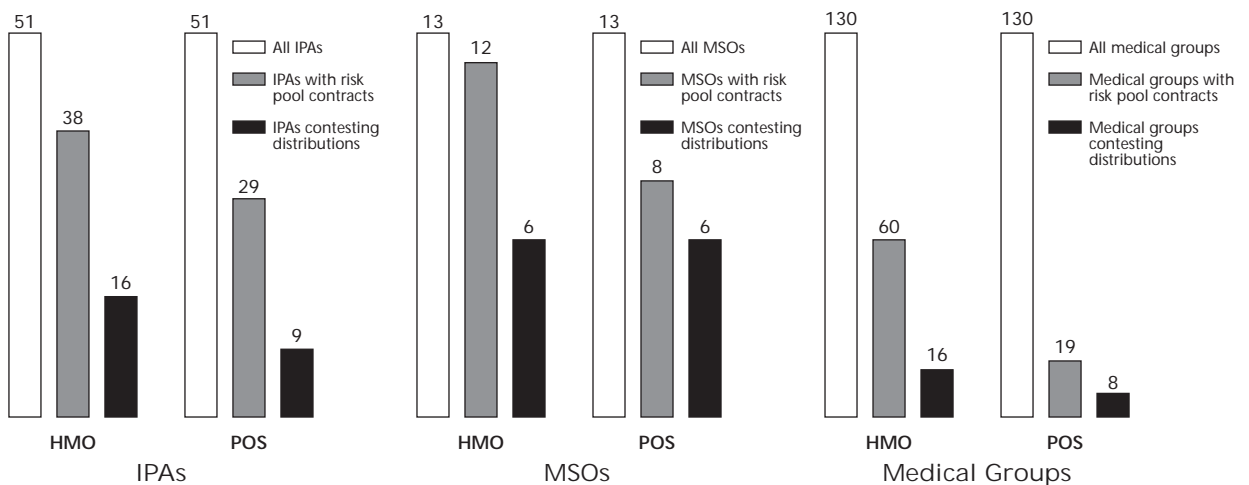
health plans, IPAs, and medical groups are estimating that the risk pool surplus will compensate for what could be a lower agreed-upon capitation rate.

All seven of the health plans reported they have established risk pools with IPAs and medical groups. The number of organizations with which commercial HMOs share risk ranges up to 277 with a median of 91. POS plans reported up to 250 organizations with which they have established a risk pool, with a median of 73. Five of the 7 health plans reported sending quarterly summaries of transactions against the risk pools for their HMOs and POS plans to the appropriate MSOs and IPAs. Another health plan reported sending these summaries annually.

As shown in Figure 6, 38 of 51 IPAs reported they have at least one risk pool contract with commercial HMOs, and 29 reported they have at least one risk pool contract with POS plans. In addition, 60 of 130 medical groups reported they have at least 1 risk pool contract with commercial HMOs and 19 have at least 1 contract with POS plans. Further, 12 of 13 MSOs reported that the IPAs or medical groups they administered had at least one risk pool contract with commercial HMOs and 8 reported the IPAs or medical groups they administered had at least one risk pool contract with POS plans.

**FIGURE 6**

**MSOs, IPAs, and Medical Groups With Risk Pool Contracts and Number Contesting Risk Pool Distributions**



Most of the MSOs and IPAs with risk pools reported that during calendar year 1998 they received risk pool distributions from HMOs and POS plans within 9 months of the close of the applicable risk pool year. Medical groups reported a somewhat different experience with risk pool distributions. Of the 36 medical groups providing any information about risk pool distributions from HMOs, 10 reported receiving nothing and another 21 reported receiving their HMO risk pool distributions within 9 months of the close of the applicable risk pool year. Of the 24 medical groups providing information about POS plan risk pool distributions, 12 reported receiving nothing and another 10 reported receiving their risk pool distributions from POS plans within 9 months of the close of the applicable risk pool year.

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*Most of the MSO, IPA, and medical group survey respondents reported receiving summaries of the transactions against the risk pools.*

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In addition, most of the MSO, IPA, and medical group survey respondents reported receiving summaries of the transactions against the risk pools. Sixteen of the medical group respondents contested risk pool distributions from HMOs and 8 contested risk pool distributions from POS plans. However, nearly half of the MSO and IPA respondents that received risk pool distributions contested them. For example, 6 of 8 MSOs that manage IPAs or medical groups participating in risk pools with POS plans contested all or part of the distributions, and 16 of 38 IPAs that participated in risk pools with HMOs contested at least a portion of the distributions. These responses can be interpreted in two different ways. Either the information health plans distributed about the risk pools was not sufficient for the MSOs and IPAs to determine that the distributions were correct, or the MSOs and IPAs disagreed with the accuracy of the underlying information about the distributions. In either case, the results indicated that MSOs and IPAs are concerned about accuracy related to risk pool issues.

### **Many IPAs Reported They Made Risk Pool Payments to Their Affiliated Physicians**

The IPAs, in turn, may allocate risk pool distributions to their affiliated physicians and medical groups. Of the 39 IPAs that participated in risk pools with HMOs or POS plans, 23 reported paying risk pool distributions to their affiliated physicians and medical groups within 9 months, and another reported paying within 12 months. The remaining 14 IPAs said they had no surplus, and did not make any payments to their physicians and medical groups. In addition, 25 of 39 IPAs reported they did not send summaries of transactions to providers.



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*While 23 of 39 IPAs that participated in risk pools reported making distributions within 9 months, 14 reported no surpluses.*

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The proportions of IPAs reporting paying risk pool distributions and of medical groups receiving risk pool distributions from IPAs were very similar. Of the 31 medical groups providing any information about risk pool distributions from IPAs, 10 reported receiving nothing and another 18 reported receiving risk pool distributions within 9 months of the close of the applicable risk pool year. Only 2 of the medical group respondents reported contesting risk pool distributions from IPAs. Four of the 14 narrative comments from medical groups about risk pool distributions from IPAs cited a lack of information with which to verify the distribution amount. Another 4 of the narrative comments indicated that the IPAs had not made risk pool distributions to the medical groups.

Realistically, not all IPAs will be able to make risk pool distributions to their physicians and medical groups. Since the IPA must remain solvent, it must balance the cost of care it pays for to the income it receives (both capitation payments and risk pool distributions) before determining whether there is any money left to distribute to its affiliates.

## **ELECTRONIC CLAIM SUBMISSION AND PAYMENT MAY IMPROVE TIMELINESS**

All of our surveys included questions about the capability of the various entities to submit or accept claims and make payments electronically. We hypothesized that to the extent claims are sent and paid electronically rather than by regular mail, payments will be more rapid. Varying numbers within each type of entity have the capability to send or accept claims and make payments electronically. The actual use of this technology also varies.

Six of the health plans reported paying between 44 percent and 71 percent of their capitation payments electronically. None of the MSOs in our survey pay capitation payments electronically, and of the 35 IPAs who indicated they make capitation payments, only 3 do so electronically. As noted earlier, MSOs and IPAs indicated they did not experience significant delays in capitation payments from health plans during calendar year 1998. Conversely, the medical groups and physicians results we discuss in Chapter 1 show that the providers experienced more delays in capitation payments from IPAs. A certain amount of this perceived delay could be a function of the additional time required for mailing checks.

For claims, all seven of the health plans have the capability of accepting claims electronically, and they reported accepting between 0 percent and 60 percent of their claims by that method. Four of the health plans that pay claims reported they use a combination of both hard-copy check and electronic payments. Only 6 of 13 MSOs send claims to health plans electronically, but 3 of those send over 65 percent of their claims electronically.

Seven of 13 MSOs and 26 of 51 IPAs reported being able to accept claims electronically. Although the highest level of claims received electronically by an MSO is currently 15 percent, 9 of the MSOs responding to our survey intend to substantially increase the number of claims they receive electronically over the next two years. The IPAs receive a higher number of claims electronically, with 4 reporting they process between 50 percent and 99 percent of total claims electronically. Another 16 receive less than half of the claims they process electronically, and 6 receive none. Only 4 of the IPAs reported they pay claims electronically, and none of the MSOs do. In summary, although some of the entities have the capability to electronically accept and pay claims, they are not using it consistently. With increased usage, they may have a more efficient payment flow, particularly if all entities involved use electronic transmittal.

## COMPLAINT RESOLUTION PROCESSES ARE AVAILABLE

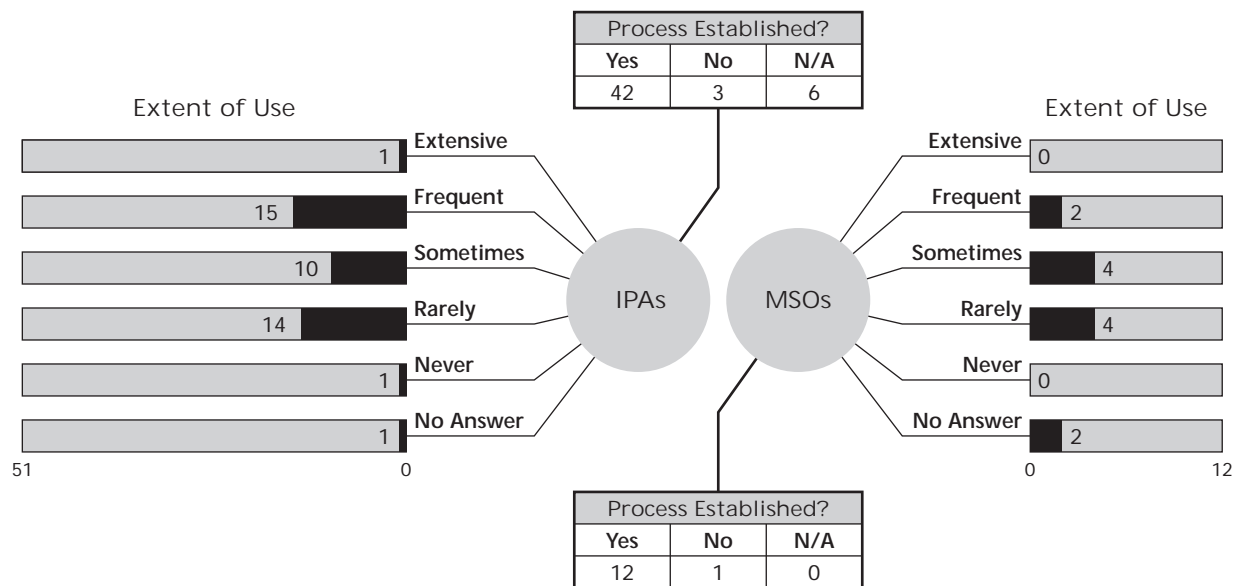
Various entities in the health care industry have established processes for the resolution of complaints from others about their payment of claims. In adjudicating claims, IPAs, MSOs, and health plans reject or delay payments for a number of reasons. Based on the results of all our surveys, some common reasons for disputed and rejected claims, other than the need for claimants to supply additional information to complete the claim request, are ineligibility of beneficiaries, lack of required preauthorization, and lack of coverage for the service provided. A provider who is not satisfied with the initial decision a health plan or other payer makes can appeal through the payer's complaint resolution process.

Recognizing the importance of this process, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) requires all health plans subject to its provisions to have such a process

available to providers. Although the Knox-Keene Act applies only to HMOs and certain PPOs, some IPAs, and MSOs have also established complaint resolution processes. As Figure 7 indicates, most of the IPAs and MSOs we surveyed have established such a process.

**FIGURE 7**

**Payers Report Varied Use of Their Complaint Resolution Process**



Those responding to the survey report varying degrees of usage of their complaint resolution processes, with most indicating moderate usage and only one reporting extensive usage.

We also asked medical groups, IPAs, and MSOs about their level of satisfaction with health plans' complaint resolution processes. Of the 70 medical groups that had used the complaint resolution process, 39 reported that in some cases the process is more

trouble than it is worth and 29 reported that in some cases the resolution is unfair. The IPAs that had used the complaint resolution process were generally more satisfied with them. None of the 23 IPAs responding to this question reported being treated unfairly, and only 7 thought the process was more trouble than it is worth. We had only 5 responses from MSOs that actually used a health plan's complaint resolution process, 2 of which thought the process is fair, while the others see it as unfair or not worth the effort.

In general, the results of our surveys of intermediaries, including medical groups indicate that, although health plan complaint resolution processes are available for settling disputes, some respondents perceive the process to be cumbersome and time-consuming. Consequently, we are concerned the perception that the complaint resolution process is difficult may cause some to challenge only those disputes involving higher dollar amounts. In such a situation, providers may tolerate individual payments that are lower than they believe appropriate but that cumulatively could have a significant impact on their income.

### **IN THE INDUSTRY'S COMPLICATED ADMINISTRATIVE ENVIRONMENT, CLEAR COMMUNICATION IS NEEDED**

In summing up the results of the surveys, we found that the administration of the health care industry in California is complex, with obvious potential for miscommunication and delays in many areas. The numerous contracts—between health plans and intermediaries, IPAs and medical groups, or IPAs and physicians—tailored to the individual needs of the contracting parties create a potential gridlock for collecting information and processing transactions. Although the perspectives of respondents to our five surveys were similar in some areas, given the complexity of the environment, the diversity of opinion in other areas is not surprising. This diversity does not necessarily mean that any one group of respondents was self-serving or less than forthright in its responses. Instead, it may very well illustrate the differences in experiences that each group has from the others.

Examining the issue of late fee-for-service payments from IPAs may illustrate how different experiences could affect perceptions. The IPAs indicated they were paid by health plans on a timely basis and that they pay the majority of the claims they process within 45 days. However, many physicians and medical groups identified the IPAs as one of the least timely payers. Part of this difference in perspective could be due to physicians “starting the clock” when the service is provided rather than when billed, claims being incomplete when initially sent in by the physician group, services billed at higher than contracted rates, and manual processes at the IPA being overloaded. Further, the IPA may not be able to pay certain claims from physicians until eligibility issues with the health plan are resolved. Each of these reasons could affect not only the timing but the amount of the payment made by the IPA. ■

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# CHAPTER 3

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## *An Important Segment of the Health Care Industry Is Unregulated*

### CHAPTER SUMMARY

**O**ur survey results raise implications about California's regulatory structure over the health care industry. Health care is vital to the welfare of Californians and, in some instances, the State extensively regulates the industry to maintain the well-being of residents. Other areas of the health care industry, however, are regulated only indirectly or not at all. For example, most preferred provider organizations (PPOs), the second most used type of health plan in California, are only indirectly regulated. The State also does not directly regulate intermediary entities, including independent practice associations (IPAs). The number of intermediaries operating within California is not known, but their role in the health care industry is important; yet many are unregulated.

Moreover, some of the current statutory requirements lose their strength or are difficult to enforce because intermediary entities have taken over some administrative functions. Regulations that apply to health plans, such as those limiting administrative charges, do not address the effect of administrative costs incurred by intermediaries. Similarly, regulations requiring prompt payment of providers' claims are difficult to enforce when payments pass through several hands before reaching the providers.

### THE STATE REGULATES SOME HEALTH CARE ENTITIES AND NOT OTHERS

California law establishes a state role in ensuring the viability of certain entities in the health care industry and, in some instances, the propriety of the services they render. As the following table indicates, the State has not concentrated regulatory responsibilities in a single department, and certain managed health care players may be subject to the regulations of more than one state department. For example, the Department of

Corporations enforces the compliance of the health maintenance organization (HMO) portion of a company’s services with the provisions of the State’s Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), but the Department of Health Services regulates the company’s Medi-Cal activities. In contrast, although they make up a small part of the health care system, insurance companies are under the regulation of a single state department, the Department of Insurance. The need for a single state agency to regulate the managed health care industry has been the subject of discussion in reports from the Managed Health Care Improvement Task Force and the Bureau of State Audits, among others.

**TABLE**  
**Intermediary Organizations and Some Health Plans  
 Are Not Regulated by the State**

Organization	Regulated	Not Regulated
<b>Providers of Services</b>		
• Physicians	✓ See Note 1	
• Medical groups	✓ See Note 1	
<b>Intermediary Organizations</b>		
• IPAs		✓ See Note 5
• PPMCs		✓ See Note 5
• MSOs		✓ See Note 5
<b>Health Plans</b>		
• HMOs	✓ See Note 2	
• POSs	✓ See Note 2	
• PPOs		✓ See Note 4
• Managed indemnity plan	✓ See Note 3	

Note 1: Provision of medical services by physicians is overseen by the Department of Consumer Affairs’ Health Boards and the Department of Health Services.

Note 2: Regulated by the Department of Corporations and, if it participates in Medi-Cal, the Department of Health Services.

Note 3: Regulated by the Department of Insurance.

Note 4: Some are regulated directly by the Department of Corporations. The Departments of Corporations or Insurance may regulate the companies that offer other PPOs, but not the plans themselves. Some may not be regulated at all.

Note 5: Not directly regulated, but may have a limited license granted by the Department of Corporations under the Knox-Keene Act.



Despite extensive regulations and the involvement of several state departments, some elements of the health care industry have little or no regulatory oversight. Entities without direct and consistent state oversight include PPOs and a variety of intermediary entities. The State does minimal or no review of the fiscal viability of many of these entities, nor does a state department ensure that they pay providers promptly, charge reasonable amounts for the administrative services they provide, or pay for appropriate medical services.

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*Unlike HMOs and indemnity insurance, PPOs are usually not directly regulated in California.*

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### Not All Health Plans Are Directly Regulated Under State Law

Of all the types of health plans offering coverage in California, PPOs are second only to HMOs in the number of insured residents they serve who are under 65 years of age. Thus, they clearly are important players in California health care. Further, some health care providers reported problems with delayed payments from PPOs. Unlike HMOs and indemnity insurance, however, PPOs are usually not directly regulated in California, and some are not subject to any state regulation. The Department of Insurance does not license PPOs. Similarly, the Department of Corporations also does not generally license PPOs directly; instead, it licenses and monitors the companies regulated under the Knox-Keene Act that offer these plans as options. Conversely, if PPOs are offered by companies exempt from licensure, the PPOs are also exempt.

In some cases, depending on the nature of the payment structure, the Department of Corporations directly licenses a PPO that falls under the definition of a health care service plan. Citing language in the Knox-Keene Act, Department of Corporations' legal staff stated that it regulates only those PPOs that receive periodic or prepaid charges for their services. Thus, for example, a PPO receiving capitation payments from individuals, employers, or employer groups for its administrative services would be subject to regulation, whereas one receiving payment based only on the amount of its work—a flat rate for each claim processed, for example—would not. The Department of Corporations licenses a limited number of PPOs.

### Few Intermediaries Are Regulated, and Some of These Are Financially Troubled

Most health care intermediaries, such as medical groups, IPAs, and MSOs, are not licensed, monitored, or directly regulated by any state regulatory department. Although health plans

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*Most health care intermediaries, such as medical groups, IPAs, and MSOs, are not licensed, monitored, or directly regulated by any state department.*

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contracting with intermediaries are required to monitor the fiscal soundness of these contractors and conduct utilization reviews of the health care services provided, the regulations do not prescribe specific monitoring procedures. The intent of the regulations is to allow each plan flexibility in meeting requirements, but as a result, this monitoring is not consistent in either its extent or nature. For example, the seven health plans responding to our survey indicated they perform a range of little to moderate utilization review of IPAs and medical groups under their HMO line of business. The lack of both central oversight of all intermediaries and consistency in health plans' monitoring of intermediaries raises questions about the adequacy of the current monitoring mechanisms.

Moreover, health plan oversight of these contractors is not efficient or necessarily wise from a business point of view. Intermediaries contracting with many health plans are subject to monitoring by each. The redundant reviews could increase costs, but add little value. Also, the information they collect for reviewing fiscal matters could prove an advantage for health plans when they negotiate new contracts with these same entities.

This lack of consistent regulatory oversight is especially important in light of the responses to our surveys and recent events. As we noted earlier, certain activities of IPAs—their ability to pay promptly for example—raise some substantial concerns among other segments of the health care industry. PPOs' lack of prompt payment on fee-for-service claims raised similar concerns.

In a few instances, the Department of Corporations has granted a "limited license" to an intermediary organization seeking to operate as a health care service plan in California. Entities applying for a limited license request waivers or exemptions from certain requirements of the Knox-Keene Act and the related California Code of Regulations. With a limited license, an entity can assume risk, but it must market its services through a contract with a fully licensed health care service plan rather than directly to the public.

As of July 1998, the Department of Corporations had issued eight limited licenses. One of these limited licensees, FPA Medical Management Inc., has filed for bankruptcy, leaving approximately 1,500 California physicians with an estimated \$60 million owed to them and disrupting medical services to approximately 400,000 consumers. In March 1999, the Department of Corporations

appointed a conservator to take possession of the business and property of another even larger limited licensee, MedPartners Provider Network Inc., with a reported 1,000 physicians serving over 1 million residents. Thus, even with some oversight by the State and health plans, two large intermediaries have financial problems with serious consequences for the health care industry.

## INTERMEDIARIES ADD TO THE DIFFICULTY OF MONITORING COMPLIANCE

Monitoring compliance with two important mandates for health plan administration under the Knox-Keene Act becomes difficult when medical groups, IPAs, or MSOs take over functions originally performed by the health plans. The Knox-Keene Act requires HMOs to make payments within 45 days of receiving claims they do not contest and requires other health plans regulated under the act to pay claims they do not contest within 30 days. Health plans are to pay interest on any uncontested claims not paid within these deadlines. This legislation is designed to ensure reasonably prompt payment for medical services and provide additional compensation for delays that are not the providers' fault. The law also states that the obligation of the plan to comply is not waived when it contracts with medical groups, IPAs, or other entities to pay claims for covered services.

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*Payment timing laws are not waived when health plans contract with medical groups, IPAs, or other intermediaries. However, monitoring compliance with these laws is difficult when there are several entities involved.*

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However, tracking and timing the handling of payments by various entities make monitoring of compliance more difficult. Instead of reviewing the payment cycle at a single entity—the health plan—the regulatory department would have to review and track the processing of claims at each of the entities to identify who is noncompliant. At this point, the State does not even have a complete list of all intermediary entities operating within its borders.

Another important mandate is designed to limit administrative costs. We did not identify the extent of the impact intermediaries have on administrative costs in the industry. The Knox-Keene Act prohibits health plans from charging excessive administrative costs, and the implementing section of the California Code of Regulations specifies the limitations: 15 percent of revenues from premiums and related sources for established plans, and 25 percent for plans in operation less than five years. If its administrative costs exceed those levels, the plan must demonstrate to the Department of Corporations that the costs are justified or are being reduced. Under the regulations,

allowable administrative charges include the cost of receiving, processing, and paying claims, a function often assumed in part by intermediaries. The regulations do not address the impact of intermediaries assuming this function, which is one of several functions the health plans have, on the allowable administrative charges for the health plan. Further, the regulations do not impose any limitations on the administrative charges that intermediaries themselves can charge.

## THE LAW DOES NOT ADDRESS OTHER ISSUES IDENTIFIED IN THE SURVEYS

The responses to our surveys identified several other potential problem areas that are not addressed in the Knox-Keene Act or other legislation. For example, some physicians have expressed concerns about late capitation payments. Although most HMO payments are by capitation, the regulations do not require timeliness of capitation payments. Thus, the benefit to providers from the legislated deadlines for HMO plans may be relatively limited. Our surveys identified two other areas of concern, both relating to the quality of information about payments: the extent of information available to providers about transactions affecting risk pool money and the accuracy of information on enrollment lists. Existing legislation does not specifically address either of these issues.

## RECOMMENDATIONS

The Legislature should consider doing the following:

- Establish direct state regulation over the activities of health plans not currently regulated or monitored and replace the current, redundant oversight by health plans over health care intermediaries with centralized state regulation. As part of this regulation, consider requiring all involved entities to provide at least semiannual financial statements, one of which is audited, to a designated state regulatory department.
- Require health plans to submit to providers and intermediaries enrollment lists that are the basis for capitation payments. Thus, the data for the payment should be identical to the information on the enrollment lists.

- Reexamine the provisions of the Knox-Keene Act related to the limitation on health plans' administrative fees for instances when intermediaries take on any of the several administrative functions of the health plans. Also, consider establishing limits on administrative fees charged by intermediaries and establishing a system for centrally monitoring the compliance of all applicable health care entities with these limits.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



KURT R. SJOBERG  
State Auditor

Date: March 30, 1999

Staff: Lois Benson, CPA, Audit Principal  
Nancy Woodward, CPA  
Farra Bracht

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# APPENDIX A

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## *Glossary of Common Terms*

**A**s do other industries, managed health care uses certain terms and acronyms that have specific meanings unique to its environment. Adding to an already complex industry, some of these terms have several somewhat different meanings and others are used interchangeably. Although many terms other than those listed below are used in the managed health care industry, we chose to define terms related to the flow of payments that we use in this report. We obtained the definitions from various sources, including literature about the industry.

**Adjudication**—The processing of claims according to the terms of the contract. Claim adjudication is usually used to determine fee-for-service payments.

**Administrative costs**—Costs related to utilization review, insurance marketing, medical underwriting, agents' commissions, premium collection, claims processing, insurer profit, quality assurance programs, and risk management. Depending on where the activity occurs, administrative costs are not limited to those incurred by health plans but can include those incurred by physician organizations, such as independent practice associations.

**Beneficiary**—Any person eligible as either a subscriber or a dependent for a managed care service in accordance with a contract. Also called enrollee, member, patient, or consumer.

**Capitation**—A set dollar payment per beneficiary, per unit of time (usually a month) that is paid to cover a specified set of services and administrative costs without regard to the actual number or the cost of services provided. (See dual-risk capitation, full-risk capitation, and shared-risk capitation.)

**Case rate**—A flat rate paid for a beneficiary's treatment based on the diagnosis. For this fee, the provider covers all of the services the beneficiary requires for a specific period of time. Usually seen in contracts between the beneficiary's primary provider and a provider of specialized services.

**Claims review**—The method by which a beneficiary’s health care service claims are reviewed prior to reimbursement. The purpose is to validate the medical necessity of the provided services and ensure the cost of the service does not exceed the agreed-upon rate.

**Discounted fee-for-service**—An agreed-upon rate for service between the provider and payer that is usually less than the provider’s full fee. This may be a fixed amount per service or a percentage discount.

**Downcoding**—A change of codes by a payer on a submitted claim to a lower level of service or lesser procedure.

**Dual-risk capitation**—A type of capitation where the physician organization and hospital organizations negotiate separately and are capitated separately for all medical services for beneficiaries through capitation contracts with the health plan.

**Employer purchasing groups**—A coalition of employers that contracts with health plans to provide their employees health benefits.

**Fee-for-service payment**—A method of payment for medical care services where a provider receives an individual payment for each medical service provided. In California, fee-for-service is predominately a discounted fee-for-service. (See discounted fee-for-service.)

**Full-risk capitation**—A type of capitation where the health care provider organization takes full risk for all professional and institutional services to eligible beneficiaries in exchange for a per member per month capitation payment. Before a physician organization can accept full-risk capitation, it must be licensed by the Department of Corporations as a limited Knox-Keene Act licensee.

**Health maintenance organization (HMO)**—A managed care plan that offers a prepaid comprehensive set of health services from a network of providers. The beneficiary has very low co-payments when obtaining medical care from network providers but has almost no coverage for any services from providers outside the HMO network.



**Independent practice association (IPA)**—A physician-owned and controlled contracting organization comprised of solo practitioners and small groups of physicians (on a nonexclusive basis) that enables the physicians to contract with payers jointly. An IPA brings together independent physicians and contracts on their behalf with different insurers and HMOs for patients. An IPA has less control over its member physicians than does a medical group, which typically owns the physicians' assets. Also called individual practice associations or independent provider associations.

**Indemnity plan**—A traditional form of health insurance where the beneficiary pays the provider for medical services and then is reimbursed by the insurance company for covered expenses. An indemnity insurance contract usually defines the maximum amounts that will be paid for covered services.

**Managed care**—Any system of health service payment or delivery arrangement where the health plan attempts to control or coordinate the use of health services by its beneficiaries in order to contain health expenditures, improve quality, or both.

**Management services organization (MSO)**—An entity that contracts with providers, medical groups, or independent practice associations to provide business-related services, such as administration, contract negotiations with health plans, and access to capital.

**Medical group practice**—The provision of health care services by three or more physicians who are formally organized as a legal entity in which business and clinical facilities, records, and personnel are shared. Income from medical services provided by members of the group is treated as receipts of the group and is distributed according to a prearranged plan.

**Physician practice management company (PPMC)**—An organization that purchases the assets of a provider practice and works with the practice, usually through a management services organization, to handle administrative functions, negotiate contracts, and access capital.

**Point of service (POS) plan**—A product offered by health plans or indemnity insurers that combines health maintenance organization features and out-of-network coverage with economic incentives for using network providers.

**Preferred provider organization (PPO)**—A health care benefit arrangement that offers financial incentives, such as low out-of-pocket prices, to beneficiaries who obtain medical care from a preset list of physicians and hospitals. A PPO will cover a certain portion of medical services obtained from other providers. PPOs contract with individual physicians and pay them on a discounted fee-for-service basis.

**Primary care**—Basic or general health care usually rendered by general practitioners, family practitioners, internists, obstetricians, and pediatricians, who are often referred to as primary care providers.

**Provider**—A general term that encompasses physicians and other appropriately credentialed health professionals operating within the scope of their practices, and facilities, including hospitals, acute care centers, community health centers and clinics, and ancillary service suppliers.

**Risk pool**—In a capitation payment environment, a health plan sets aside an agreed-upon per member per month amount in a risk pool that is used to cover designated medical services, usually hospital or pharmacy services, that the physician organization is not then responsible for paying. The health plan pays for these services and divides any money left in the pool with the physician organization. If there is a shortfall in risk pool funds, the health plan and physician organization share the liability.

**Shared-risk capitation**—A type of capitation where the physician organization receives capitation payments only for professional services. The health plan and physician organization share the risk for other medical services, such as hospital or pharmacy services, through a risk pool.

**Sub-capitation**—A payment arrangement that exists when an organization paid under a capitated system contracts with other providers on a capitated basis, sharing a portion of the original capitated premium.

**Utilization**—Use of services. Utilization is commonly reviewed in terms of patterns or rates of use of a single service or type of service, such as hospital care, physician visits, or prescription drugs. Measurement of utilization of all medical services in total

is usually done in terms of dollar expenditures. Use is expressed in rates per unit of population at risk for a given period, such as the number of visits to a physician per person per year for an annual physical.

**Withhold**—A percentage of payments or set dollar amounts deducted from a service fee, capitation, or salary payment, that may or may not be returned depending on specific predetermined factors.

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# APPENDIX B

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## *Profile of Respondents*

**T**o assess the extent of delayed payments and its impact on physicians, we surveyed physicians and health care plans. During the course of our inquiries, we determined that intermediary organizations, including medical groups, independent practice associations, management services organizations, hospital-based foundations, and physician practice management companies, played critical roles in the adjudication and payment of physician claims and capitation payments. We therefore surveyed these entities as well.

### PROFILE OF PHYSICIAN SURVEY RESPONDENTS

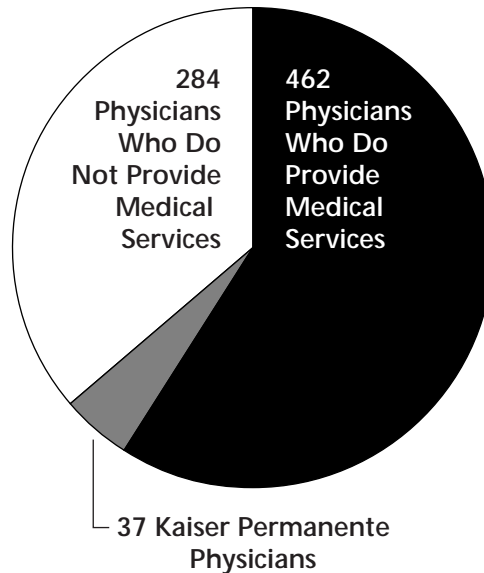
We obtained a listing of all licensed physicians in the State (74,104) from the Medical Board of California in the Department of Consumer Affairs. From this listing, we eliminated all identifiable physicians primarily working for Kaiser Permanente because these physicians contract exclusively with Kaiser and are salaried rather than paid on a fee-for-service or capitation basis by multiple health care plans.

Our consultant estimated that approximately 16 percent of the physicians were retired and that 15 percent were in research or academic medicine and anticipated a 40 percent response rate. Using an error rate of +/-3 percent, our consultant estimated that we needed a final sample of 384. Accounting for the retired and academic or research physicians made necessary a final sample of 520. Applying the expected 40 percent response rate meant that we needed to survey a random sample of 1,300 physicians. We mailed surveys to 1,300 physicians and sent a second mailing to the physicians who did not respond to the first mailing, in an effort to boost the response rate. The final response rate was 60 percent, or 783 physicians.

As shown in Figure 8, we received 783 survey responses and of those 462 were from physicians who provide medical services. In addition to the 462 physicians, 284 returned surveys indicating they did not spend most of their workday seeing patients. Most likely, these physicians did not provide medical services because they were retired or worked in an academic or administrative setting, and therefore did not deal with claims reimbursement or were not capitated. We also received 37 surveys from physicians who primarily worked for Kaiser. We used the 462 surveys from practicing physicians for our final analysis.

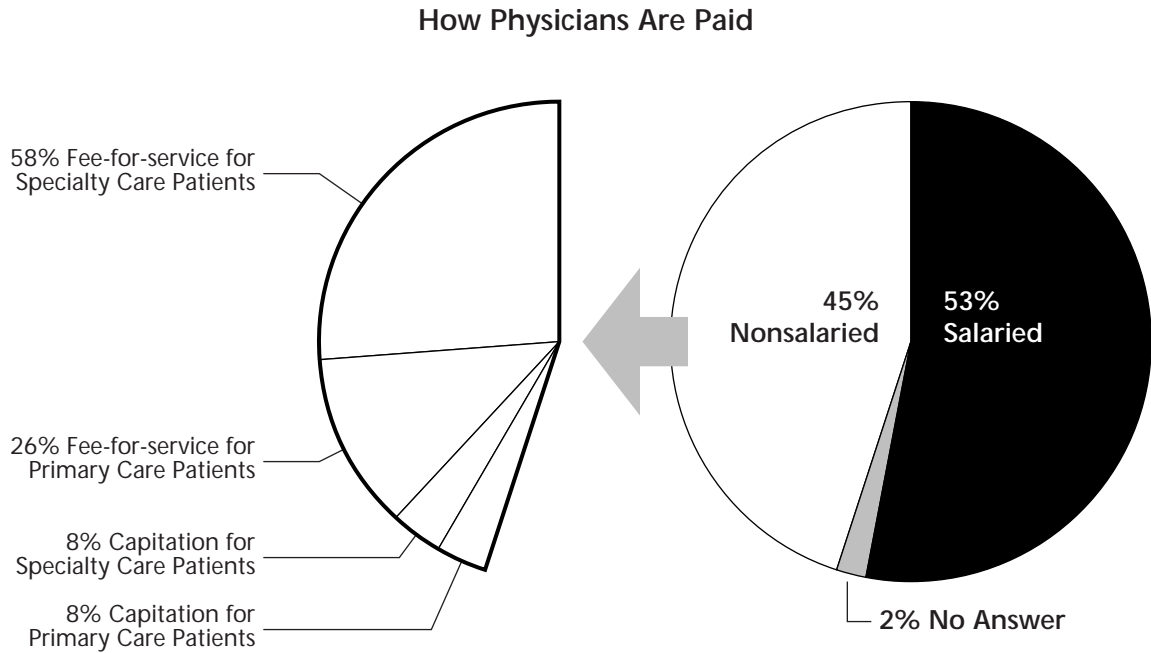
**FIGURE 8**

Who Responded to the 1,300 Physician Surveys We Mailed



In Chapter 1, Figure 2 shows the responding individual physicians' medical group size. Figure 9 shows how our respondents were paid. Most of the nonsalaried physicians responding receive fee-for-service payments for specialty patients.

FIGURE 9



### PROFILE OF MEDICAL GROUP SURVEY RESPONDENTS

We determined that no single source could provide us with a listing of all medical groups operating within the State. We therefore compiled a listing from three separate sources:

- The California Medical Group Management Association, whose listing identified medical groups and their administrators or chief executive officers. It also contained names of other organizations that provide services to entities within the health care industry, such as CPA firms and billing agencies.
- The *California Medicine* Internet web site listing of selected medical groups.
- The *1998 Directory of Physician Groups and Networks*, published by the Center for Healthcare Information in conjunction with the IPA Association of America.

According to our consultant, of the 1,027 medical groups, information regarding the organization was available for only 86 percent (883). We also anticipated that up to 25 percent to 30 percent of the entities on the list would not qualify as medical groups. Given a desired error rate of +/- 3 percent, our consultant estimated that we needed a sample of 768. Given an expected response rate of 40 percent, it was determined that all medical groups we identified should be sampled. We used two of these medical groups to pretest our survey, resulting in a final sample of 1,025.

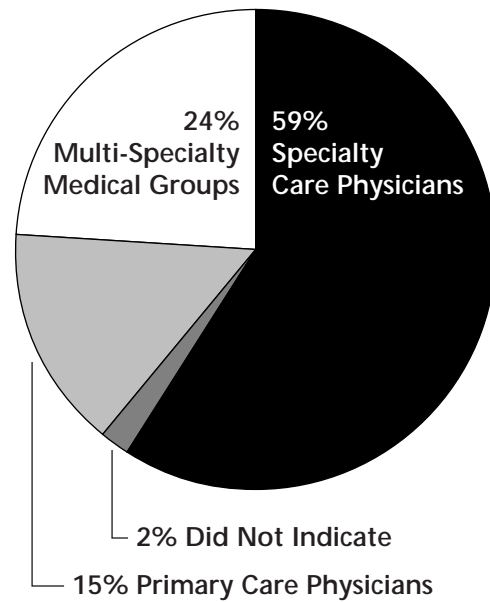
Of the 1,025 surveys mailed, we received a 23 percent response rate, which includes 130 surveys from medical group administrators and 101 letters from organizations indicating they were not medical groups. We used the 130 surveys for our final analysis. Primarily small (2 to 10 physicians) medical groups responded to our survey. This is similar to the response from physicians practicing in medical groups in the separate physician survey, shown in Chapter 1, Figure 2.

Medical groups serve two roles: to provide medical services through the individual physicians in their group and to act as payers to physicians outside their group. Of the 130 medical groups responding to our survey, 30 indicated they contract with physicians outside their group. In this role, the medical group functions like an independent practice association (IPA) and develops contractual relationships with specialists. These groups pay outside physicians on a fee-for-service, capitation, or case-rate basis. Our respondents indicated that fee-for-service reimbursement was more common. Figure 10 indicates the types of practices represented in the medical groups responding to our survey.



FIGURE 10

Composition of Medical Groups Responding to the Survey



PROFILE OF IPA SURVEY RESPONDENTS

We also found no single source identifying all IPAs operating in the State. To compile our own listing, we relied on three sources:

- The National IPA Coalition member list for the Western Region.
- The *California Medicine* Internet web site listing of selected IPAs.
- The *1998 Directory of Physician Groups and Networks*, published by the Center for Healthcare Information in conjunction with the IPA Association of America.

Using these sources, we compiled a list of 304 IPAs. Three of these pretested the survey questionnaires and were removed from the final sample. On our consultant's advice, since the number of IPAs was small and the response rate was expected to be 40 percent or less, we surveyed all remaining IPAs we identified and made follow-up phone calls to increase the response rate.

We received 60 responses from IPAs and 9 from organizations indicating they were not IPAs. The final response rate was nearly 20 percent, yielding a final sample of 51.

## PROFILE OF SURVEY RESPONDENTS FOR MANAGEMENT SERVICES ORGANIZATIONS, MEDICAL FOUNDATIONS, AND PHYSICIAN PRACTICE MANAGEMENT COMPANIES

For the survey of management services organizations (MSOs)<sup>4</sup> hospital-based foundations, and physician practice management companies, we compiled a listing from various sources:

- The California Medical Group Management Association, whose listing contained a few MSOs in addition to names of medical groups.
- The *California Medicine* Internet web site listing of selected MSOs.
- The *1998 Directory of Physician Groups and Networks*, published by the Center for Healthcare Information in conjunction with the IPA Association of America.

Our final listing consisted of 140 entities, which was reduced to a final sample of 139 after eliminating the MSO that pretested the survey questionnaire. Again, due to the small number and anticipated low response rate, we sent surveys to all 139 entities and made follow-up phone calls to those who did not respond within the original time line.

Of the 139 surveys mailed, 13 MSOs responded and 2 organizations replied that they were not MSOs. The final response rate was 11 percent, yielding a final sample of 13.

## PROFILE OF HEALTH CARE PLAN RESPONDENTS

To select the health plans we wanted to participate in our survey, we obtained from the Department of Corporations a list of all the health plans they regulate. This list identified 53 full service

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<sup>4</sup> For the purposes of this report, we are using the term management services organization (MSO) to include physician practice management companies and hospital-based foundations, as well as actual management services organizations.

plans. Although Kaiser Permanente is the largest HMO, as stated in the physician profile, we eliminated it from our survey because of its unique contractual arrangements with physicians.

Kaiser Permanente excluded, we chose the seven largest commercial health care plans operating in California to cover a large portion of the insured population. According to our consultant, as of December 31, 1998, across all product lines (including HMO, POS, PPO, EPO, and indemnity) these seven plans have a total enrollment of 12,162,341 members and cover approximately half (47 percent) of the insured population in California, including all insured persons of all ages and those enrolled in commercial plans, Medicare, and Medi-Cal. The final response rate was 100 percent, yielding a final group of seven respondents for health care plans. ■

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# APPENDIX C

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## *List of Survey Questions*

**W**e developed and administered five survey instruments to assess the impact of delayed payments to physicians. We surveyed a sample of the providers of services, which include physicians and the medical groups to which they belong. We also surveyed the payers of services, which include health plans and intermediaries responsible for performing administrative functions for providers they contract with. Some medical groups also function as intermediaries, and their survey questions reflect both roles. We did not reproduce the actual surveys, but listed the questions in this appendix that we posed to each group.

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## SURVEY OF PHYSICIANS

### Part 1—General Information

1. Do you spend most of your workday seeing patients? If yes, please go to Question 2. If no, please do not answer any of the following questions and return this questionnaire to the Bureau of State Audits.
2. Is your primary practice setting part of the Kaiser Permanente System? If yes, please do not answer any of the following questions and return this questionnaire to the Bureau of State Audits. If no, please answer the following questions.
3. In what specialty or specialties do you practice?
4. In what specialty or specialties are you board certified?
5. What percent of your time is spent doing primary care?
6. What is your main practice setting: solo practice; single specialty group; multi-specialty group; community health center or public clinic; other (please specify)?
7. In your main practice, how many physicians, including yourself, are in the practice: 1 physician; 2 to 10 physicians; 11 to 50 physicians; 51 to 100 physicians; more than 100 physicians?
8. In your main practice, how are you paid: salaried (for example, formula-based, with or without bonuses); non-salaried?
9. If you are not salaried, what percentage of your income is paid through: capitated payment for your specialty patients; capitated payment for your primary care patients; fee-for-service payment for your specialty patients; fee-for-service payment for your primary care patients?

If you are in solo practice, please continue at Part 2, Question 10.

If you are in a medical group, please continue at Part 3, Question 13.

## Part 2—Solo Practice

10. If you are in solo practice, please indicate the number of contracts you have and the percentage of your 1998 gross revenue you received from: independent practice association (IPA); medical group; commercial HMO; Medicare/Medi-Cal HMO; point of service plan (POS); preferred provider organization (PPO); exclusive provider organization (EPO); other insurance or private pay?
11. How do the top three IPAs (in terms of gross revenue) that you contract with pay you: capitation; fee-for-service; blend of capitation and fee-for-service?
12. How do the medical groups with which you contract pay you: capitation; fee-for-service; case rate?

Please continue at Part 4, Question 18.

## Part 3—Medical Group Members

13. If you are not in solo practice, indicate whether your medical group: contracts directly with health plans; contracts with health plans through one or more independent practice associations (IPAs); both of them?
14. With how many IPAs does your medical group contract?
15. Does your medical group directly provide you with all of your income from seeing patients? If no, describe the outside arrangements you have.
16. If you are a specialist, do you contract to provide services for any medical group other than your own? If yes, go to Question 17; if no, go to Question 18.
17. How do these medical groups pay you: capitation; fee-for-service; case rate?

## Part 4—Delayed Payments

18. In your experience, have commercial HMOs made capitation payments to you, your medical group, or IPA by the dates specified in the contractual agreements? If no, how frequently have you experienced delayed payments: rarely; sometimes; often?

19. In your experience, have commercial HMOs ever delayed payment of risk pool surpluses to your medical group or IPA for more than three months? If yes, how frequently have you experienced delayed payment of risk pool surpluses: rarely; sometimes; often?
20. In your experience, have you ever had reason to believe that commercial HMO payments of risk pool surpluses to your medical group or IPA were significantly inaccurate? If yes, how often has this occurred: rarely; sometimes; often? What do you believe was inaccurate about the payments?
21. Have you experienced delayed payments on fee-for-service claims from an IPA to you or to your medical group? If yes, how often has this occurred: rarely; sometimes; often?
22. Do the IPAs with which you contract make capitation payments to you by the dates specified in the contractual agreements? If no, how frequently have you experienced delayed capitation payments: rarely; sometimes; often?
23. Has an IPA ever delayed payment of with-holds or risk pool surpluses to you or your medical group for more than three months? If yes, how often has this occurred: rarely; sometimes; often?
24. Have you ever had reason to believe that IPA payment of with-holds or risk pool surpluses to you or your medical group was significantly inaccurate? If yes, how often has this occurred: rarely; sometimes; often? In your opinion, what was inaccurate?
25. Do the medical groups with whom you contract pay you promptly? If no, how often have you experienced delayed payments: rarely; sometimes; often?
26. Do the medical groups with whom you contract pay you accurately? If no, how often have you experienced inaccurate payments: rarely; sometimes; often? What do you believe was inaccurate about the payments?
27. To what extent are delayed payments caused by: medical groups that you contract with, IPAs, HMOs, POSs, PPOs, EPOs billing groups that you contract with: always; usually; sometimes; rarely; never; no opinion?



28. If you have experienced delayed payments, what impact have they had on your practice and/or how you deliver services?
29. If asked by the Bureau of State Audits, could you provide actual examples of delayed payments by payers?

## SURVEY OF MEDICAL GROUPS

### Part 1—General Information

1. Has your medical group sold its assets to a physician practice management company (PPMC) or hospital-based foundation? If yes, please provide the name of the PPMC or foundation.
2. Does a management services organization (MSO), PPMC, or foundation provide administrative services for your medical group? If yes, please provide the name of the MSO, PPMC, or foundation.
3. What is the composition of your medical group: primary care physicians only; specialty care physicians only; multi-specialty medical group?
4. How many physicians are in your medical group: 2 to 10 physicians, 11 to 50 physicians, 51 to 100 physicians, more than 100 physicians?
5. If you contract for services with physicians outside your medical group, how do you pay these physicians: capitation; fee-for-service; case rate; not applicable? Please mark all that apply.
6. Please indicate whether your medical group contracts directly with health plans, contracts with health plans through one or more independent practice associations (IPAs), or both.
7. With how many IPAs does your medical group affiliate?

8. What percentage of your 1998 gross revenue was from commercial HMO (non-Medicare, non-Medi-Cal); Medicare/Medi-Cal HMO; point of service plans (POS); preferred provider organization (PPO); exclusive provider organization (EPO); commercial indemnity; other?

## Part 2—Payment Methods, Processes, and Problems

9. If you contract directly with health plans, how do the top five commercial HMO plans (on the basis of gross revenue) with which you contract pay you for professional services: full-risk<sup>5</sup>, shared-risk<sup>6</sup>, or dual-risk<sup>7</sup> capitation?
10. In your experience during calendar year 1998, did commercial HMOs make capitation payments to you by the dates specified in your contractual agreements: always, usually, sometimes, rarely, never? If you experienced delayed capitation payments during this period, please describe the type of delays you encountered.
11. In your experience during calendar year 1998, were the capitation payments you received from commercial HMOs accurately computed: always, usually, sometimes, rarely, never? If you experienced inaccurate capitation payments during this period, please describe the inaccuracies.
12. In your experience during calendar year 1998, were the enrollment lists you received from health care plans accurate: always, usually, sometimes, rarely, never? If you experienced inaccurate enrollment lists, were the errors in the number of enrollees, risk factor data, and/or other areas? Please describe the errors.
13. Please indicate the proportion of health care plans (commercial HMOs or POSs) that provide you with updated enrollment lists monthly, quarterly, and/or other.

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<sup>5</sup> Full-risk capitation—the health care provider organization takes full risk for all professional and institutional services to eligible enrollees in exchange for a per-member, per-month capitation payment.

<sup>6</sup> Shared-risk capitation—the physician organization receives capitation payments only for professional services. The health plan and physician organization share the risk for other medical services, such as institutional or pharmacy services, through the use of a risk pool.

<sup>7</sup> Dual-risk capitation—the physician organization and hospital organizations negotiate separately and are capitated separately for all medical services for assigned members through capitation contracts with the health plan.

14. How many of your contracts with commercial HMOs and POSs include the sharing of risk through the establishment of risk pools?
15. Please indicate how frequently you receive a summary of the transactions against the risk pools from the health care plans (commercial HMOs or POSs) with which you contract: monthly, quarterly, annually. Total should equal the number of contracts in Question 14.
16. For risk pool distributions you **received** during the last 12 months, please indicate the percentage distributed to you within the following time periods after the close of the applicable risk pool year for commercial HMOs, POSs, and/or IPAs: within 3 months, between 3 and 6 months, between 6 and 9 months, between 9 and 12 months, more than 12 months.
17. For risk pool distributions that you **received** during the last 12 months, what percentage of the distributions did you contest for commercial HMOs, POSs, IPAs?
18. How do the top three IPAs in terms of gross revenue that you affiliate with pay you for primary care physician services: capitation, fee-for-service, blend of capitation and fee-for-service?
19. How do the top three IPAs in terms of gross revenue that you affiliate with pay you for specialty physician services: capitation, fee-for-service, blend of capitation and fee-for-service?
20. In your experience during calendar year 1998, did the IPAs with which you affiliate make capitation payments to you by the dates specified in your agreements: always, usually, sometimes, rarely, never? If you experienced delayed capitation payments during this period, please describe the type of delays you encountered.
21. During calendar year 1998, did IPAs delay any payments of with-holds or risk pool surpluses to your medical group for more than three months? If yes, how often did this occur: always, usually, sometimes, rarely?

22. Do you believe that IPA payments of with-holds or risk pool surpluses to your medical group were significantly inaccurate during calendar year 1998? If yes, how often did this occur: always, usually, sometimes, rarely? In your opinion, what was inaccurate?
23. During calendar year 1998, did your medical group experience instances where IPAs took longer than 60 days from the date of billing to pay your fee-for-service claims? If yes, how often did this occur: always, usually, sometimes, rarely.
24. During calendar year 1998, did your medical group experience instances when IPAs paid fee-for-service claims at a lower amount than the contracted rate? If yes, how often did this occur: always, usually, sometimes, rarely?
25. Do you have the capability to send claims electronically to the health plans, IPAs, or MSO that pay your claims? If yes, what percentage of claims do you send electronically?
26. Do you track the length of time it takes for claims you submit to be paid? If asked by the Bureau of State Audits, could you provide documentation of the tracking of specific claims?
27. For calendar year 1998, please indicate the range of days after billing uncontested claims that you received payment from the top three (on the basis of gross revenue) POSs, PPOs, and other entities (such as indemnity companies, EPOs, or HMOs) with which you contract: 30 days or less; 30 to 45 days; 45 to 60 days; over 60 days; do not track this information; not applicable.
28. For calendar year 1998, please indicate how often, if at all, you experienced having to resubmit claims to the PPMC, foundation, or MSO; IPA; commercial HMO plans; POS plans; PPO plans; EPO plans; indemnity plans: never, rarely, sometimes, usually, always.
29. For calendar year 1998, what percentage of the claims you submitted were contested or denied for PPMCs, foundations, or MSOs; IPAs; POS plans; PPO plans; other.

30. For calendar year 1998, please rank from 1 to 10, with 1 being the most frequent reason and 10 the least frequent, the reasons given by the following entities (MSO, IPA, PPO, POS, other) for contesting or denying claims you submitted: beneficiary not eligible; service not medically necessary; service not a covered benefit; services provided do not match services authorized; required preauthorization not obtained; claim incomplete; claim previously denied; claim not filed within filing limits; duplicate claim; other.
31. In your experience during calendar year 1998, were there claims for particular kinds of services or specialties that payers were less likely to process within 30 to 45 days? If yes, please name these services or specialties.
32. How frequently do commercial HMO plans, other health plans, and/or other entities that pay you include interest on delayed payments (capitation, fee-for-service, or both): never, rarely, sometimes, usually, always?
33. Do you track claims for which you received payment that was less than the contracted rate (or downcoded)?
34. During calendar year 1998, what was the percentage of claims for which you received payment at a lower amount than the contracted rate for PPMCs, foundations, or MSOs; IPAs; POS plans; PPO plans; Other?
35. For calendar year 1998, please rank from 1 to 5 the most frequent reasons given by the following entities (MSO, IPA, PPO, POS, Other) for paying a lower amount than the contracted rate on claims you submitted, with 1 being the most frequent reason and 5 the least frequent reason: service code combinations bundled differently than billed; change in payment rate; others (specify).
36. For calendar year 1998, please indicate the proportion of difficulty you experienced with obtaining information from each type of entity that affected the timing of your receiving claims or capitation payments for PPMCs, foundations, or MSOs; IPAs; commercial HMO plans; PPO plans; other health plans; very difficult, somewhat difficult, no difficulties, not applicable.

37. For payment-related complaints that you had with health plans, did you use the dispute resolution processes set up by the health plans to resolve the complaint or problem? If yes, what was your opinion of the dispute resolution process: complaint settled (resolution was fair to both medical group and health plan); complaint settled (process was more trouble than it was worth); complaint settled (resolution was not fair to medical group); dispute still in process?
38. For claims from physicians outside your medical group that you pay, do you track the claims from the date they were submitted to you to the date that you pay them?
39. During calendar year 1998, what was your average number of days to pay claims that were valid and complete: less than 30 days, 30 to 45 days, 45 to 60 days, more than 60 days.
40. During calendar year 1998, what percentage of the claims you **received** and processed fell into the following categories: paid within 45 days; payment delayed more than 45 days, initial claim ruled incomplete; delayed more than 45 days, claim still pending; denied, beneficiary not eligible; denied, not a covered benefit; denied, not medically necessary?
41. In your experience during calendar year 1998, to what extent do you agree that HMOs cause delayed payments; PPOs cause delayed payments; POSs cause delayed payments; other types of health plans (EPO, indemnity, etc.) cause delayed payments; my PPMC, foundation, or MSO causes delayed payments; IPAs cause delayed payments; other medical groups with which we contract cause delayed payments: strongly agree, somewhat agree, somewhat disagree, strongly disagree, not applicable.
42. If asked by the Bureau of State Audits, could you provide actual examples of late payments by payers for capitated payments, claims payments, and/or risk pool distributions.

### Part 3—Impact on Practice

43. During calendar year 1998, how did the number of patients for whom your medical group provides care change for the total number of patients; HMO Medi-Cal patients; Non-HMO Medi-Cal patients; HMO Medicare patients; non-HMO Medicare patients; HMO patients; non-HMO (PPO, POS, EPO or indemnity) patients; uninsured patients: increased a lot, increased a little, no change, decreased a little, decreased a lot, not applicable?
44. For those areas where you are reducing the number of patients, please indicate your reasons for doing so. Please mark all that apply: Medi-Cal or Medicare reimbursement rates are too low; administrative requirements are too burdensome; capitation rates are too low; delayed payments from health plans are causing cash flow problems; delayed payments from IPAs are causing cash flow problems; fewer patients in area are covered by this type of plan; reducing patient load in anticipation of retirement, relocation, or career change; other (specify).
45. If you have experienced delayed payments, what impact have they had on your medical group's practice and/or how you deliver services?
46. If you have experienced delayed payments, has it increased your medical group's administrative costs? If yes, please provide an estimate of the annual amount of these increased administrative costs.
47. During calendar year 1998, how much utilization review did you perform on the services rendered by physicians within your own medical group and/or physicians outside your medical group: none, little, moderate, extensive?

### SURVEY OF INDEPENDENT PRACTICE ASSOCIATIONS

1. Has your independent practice association (IPA) sold its assets to a physician practice management company (PPMC) or hospital-based foundation? If yes, please provide the name of the PPMC or foundation.

2. Does a management services organization (MSO), PPMC, or foundation provide administrative services for your IPA? If yes, please provide the name of the MSO, PPMC, or foundation.
3. What is the composition of your IPA: primary care physicians only; specialty care physicians only; or mix of primary care and specialty care physicians?
4. How do you pay (a) primary care physicians and/or (b) specialty physicians in your IPA: capitation; discounted fee-for-service; combination of capitation and fee-for-service?
5. For those physicians and group practices that you capitate, what percentage do you pay on the following capitation cycles: quarterly; bi-monthly; monthly; other?
6. Do you pay capitation payments electronically? If yes, what percentage do you pay electronically?
7. Do you have a with-hold arrangement with the physicians and group practices in your IPA? If yes, how often do you distribute the with-hold?
8. If you contract for services with physicians outside of your IPA, please indicate the percentage of payments made using the following methods: capitation; fee-for-service; case rate.
9. What percentage of your 1998 gross revenue came from the following entities: commercial HMO (non-Medicare, non-Medi-Cal); Medicare/Medi-Cal HMO; point of service plans (POS); other (specify)?
10. How do the top five commercial HMO plans (on the basis of your gross revenue) with which you contract pay you for professional services: full-risk capitation<sup>8</sup>; shared-risk capitation<sup>9</sup>; dual-risk capitation<sup>10</sup>?

<sup>8</sup>Full-risk capitation—the health care provider organization takes full risk for all professional and institutional services to eligible enrollees in exchange for a per member per month capitation payment.

<sup>9</sup>Shared-risk capitation—the physician organization receives capitation payments only for professional services. The health plan and physician organization share the risk for other medical services, such as institutional or pharmacy services, through the use of a risk pool.

<sup>10</sup>Dual-risk capitation—the physician organization and hospital organizations negotiate separately and are capitated separately for all medical services for assigned members through capitation contracts with the health plan.



11. In your experience during calendar year 1998, did commercial HMOs make capitation payments to you by the dates specified in your contractual agreements: always, usually, sometimes, rarely, never? If you experienced delayed capitation payments during this period, please describe the type of delays you encountered.
12. In your experience during calendar year 1998, were the capitation payments you received from commercial HMOs accurately computed: always, usually, sometimes, rarely, never? If you experienced inaccurate capitation payments during this period, please describe the inaccuracies.
13. In your experience during calendar year 1998, were the enrollment lists you received from health care plans accurate: always, usually, sometimes, rarely, never? If you experienced inaccurate enrollment lists, were the errors in the number of enrollees; risk factor data; other errors? Please describe the errors.
14. Please indicate the proportion of health care plans that provide you with updated enrollment lists at the following intervals: monthly; quarterly; other.
15. How many of your contracts with the following types of entities include the sharing of risk through the establishment of risk pools: commercial HMO; POS?
16. Please indicate how frequently you receive a summary of the transactions against the risk pools from the health care plans with which you contract—commercial HMO; POS—monthly; quarterly; annually.
17. For risk pool distributions you **received** during the last 12 months, please indicate the percentage distributed to you within the following time periods after the close of the applicable risk pool year within 3 months; between 3 and 6 months; between 6 and 9 months; between 9 and 12 months; more than 12 months for commercial HMOs and/or POSs.
18. For risk pool distributions that you **received** during the last 12 months, what percentage of the distributions did you contest for commercial HMOs and/or POSs.

19. For payment-related complaints that you had with health plans, did you use the dispute resolution processes set up by the health plans to resolve the complaint or problem? If yes, what was your opinion of the dispute resolution process: complaint settled (resolution was fair to both IPA and health plan); complaint settled (process was more trouble than it was worth); complaint settled (resolution was not fair to IPA); dispute still in process?
20. What is the range of time it takes you to pay risk pool distributions to the physicians and group practices in your IPA: less than 3 months; 3 to 6 months; 6 to 9 months; 9 to 12 months; more than 12 months; no surplus, so did not distribute?
21. Do you provide a summary of the transactions against the risk pool to the participating physicians? If yes, how often do you provide this summary: monthly; quarterly; annually; other (specify)?
22. Do you require the use of the HCFA 1500 form as the major element of a claims package?
23. Do you have the capability of accepting claims electronically? If yes, what percentage of claims do you receive electronically?
24. Do you track the length of time it takes you to process claims? If asked by the Bureau of State Audits, could you provide documentation of the tracking of specific claims?
25. During calendar year 1998, what was your average number of days to pay claims that were valid and complete: less than 30 days; 30 to 45 days; 45 to 60 days; more than 60 days?
26. What percentage of claims do you pay using the following methods: electronically; hard-copy check.
27. For calendar year 1998, what percentage of the claims that you received fell into the following categories: paid within 45 days; payment delayed more than 45 days, claim ruled incomplete; delayed more than 45 days, claim still pending; denied, beneficiary not eligible; denied, not a covered benefit; denied, not medically necessary?

28. For claims that you paid after 45 days, did you add interest to the amount paid?
29. For calendar year 1998, please rank from 1 to 10, with 1 being the most frequent reason and 10 the least frequent, the reasons you gave for contesting or denying claims that you received from physicians: beneficiary not eligible; service not medically necessary; service not a covered benefit; services provided do not match services authorized; required preauthorization not obtained; claim incomplete; claim previously denied; claim not filed within filing limits; duplicate claim; other (specify)?
30. In your experience during calendar year 1998, were there claims for particular kinds of services or specialties that you were less likely to process within 45 days? Please name these services or specialties.
31. During calendar year 1998, what percentage of claims did you pay at a lower amount than the contracted rate?
32. For calendar year 1998, please rank from 1 to 5, with 1 being the most frequent reason and 5 the least frequent, the reasons you gave for paying a lower amount than the contracted rate on claims that you processed and paid—categories for ranking include: service combinations bundled and paid differently than as billed; change in payment rates; others (specify)?
33. For calendar year 1998, please indicate the proportion of difficulty you experienced with obtaining information from physicians outside IPA; physicians within IPA; PPMC, foundation, or MSO; commercial HMO plans; and/or POS plans that affected the timing of your paying claims: very difficult; somewhat difficult; no difficulties?
34. During calendar year 1998, what were the five most frequent claims and/or capitation-related complaints you received from physicians and group practices?
35. Have you established a process to resolve payment disputes with physicians? If yes, how extensively is it used: never; rarely; sometimes; frequently; extensively?

36. In your experience, to what extent do you agree that HMOs cause delayed payments; POSs cause delayed payments; PPMCs, foundations, or MSOs cause delayed payments: strongly agree; somewhat agree; somewhat disagree; strongly disagree; N/A?
37. If asked by the Bureau of State Audits, could you provide actual examples of late payments by payers for: capitated payments; claims payments; risk pool distributions?
38. If you have experienced delayed payments, has it increased your IPA's administrative costs? If yes, please provide an estimate of the annual amount of these increased administrative costs.
39. During calendar year 1998, how much utilization review did you perform on the services rendered by physicians within your IPA and/or physicians outside your IPA: none; little; moderate; extensive?

#### **SURVEY OF PHYSICIAN PRACTICE MANAGEMENT COMPANIES, HOSPITAL-BASED FOUNDATIONS, AND MANAGEMENT SERVICES ORGANIZATIONS**

1. For how many medical groups or independent practice associations (IPAs) does your organization own the assets such as contracts with health plans? Please provide the names of the medical groups and IPAs for which you own assets.
2. With how many medical groups and IPAs does your organization contract to provide administrative services? Please provide the names of the medical groups and IPAs.
3. Please provide the number of medical groups and IPAs that you own or contract with that fall into the following categories (total should equal the total number of entities in Question 2.): primary care only; specialty care only; multi-specialty.
4. If your organization contracts for services from physicians outside the medical groups and IPAs that you own, please indicate the proportion of payments that you make to these physicians by the following methods: capitation; discounted fee-for-service; case rate.

5. For those physicians that you capitate, what is your capitation cycle? quarterly; bimonthly; monthly; other (specify).
6. Do you pay capitation payments electronically?
7. What percentage of your 1998 gross revenues for California health care services came from commercial HMOs (non-Medicare, non-Medi-Cal); Medicare, Medi-Cal HMO; point of service plan (POS); preferred provider organization (PPO); exclusive provider organization (EPO); other (specify)?
8. For the total number of contracts that you or your medical groups and IPAs have with commercial HMOs for California health care services, please indicate the percentage of contracts that fall into the following categories: full-risk capitation<sup>11</sup>; shared-risk capitation<sup>12</sup>; dual-risk capitation<sup>13</sup>.
9. In your experience during calendar year 1998, did commercial HMOs make capitation payments for California health care services to you or the medical groups and IPAs that you manage by the dates specified in the contractual agreements: always, usually, sometimes, rarely, never? If you experienced delayed capitation payments during this period, please describe the type and length of delays you encountered.
10. In your experience during calendar year 1998, did commercial HMOs accurately compute the capitation payments for California health care services made to you or your medical groups and IPAs: always, usually, sometimes, rarely, never, do not know? If you experienced inaccurate capitation payments during this period, please describe the inaccuracies.

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<sup>11</sup> Full-risk capitation—the health care provider organization takes full risk for all professional and institutional services to eligible enrollees in exchange for a per member per month capitation payment.

<sup>12</sup> Shared-risk capitation—the physician organization receives capitation payments only for professional services. The health plan and physician organization share the risk for other medical services, such as institutional or pharmacy services, through the use of a risk pool.

<sup>13</sup> Dual-risk capitation—the physician organization and hospital organizations negotiate separately and are capitated separately for all medical services for assigned members through capitation contracts with the health plan.

11. For how many of the medical groups and IPAs that you manage, do you receive the enrollment lists directly from the health plans: PPMC, foundation, or MSO; IPAs; medical groups?
12. In your experience during calendar year 1998, were the enrollment lists you received directly from health care plans accurate: always, usually, sometimes, rarely, never, not applicable, do not know. If you experienced inaccurate enrollment lists, were the errors in the number of enrollees, the risk factor data, or other errors? Please describe these other errors.
13. Please indicate the percentage of health care plans (commercial HMO, POS) you contract with that provide updated enrollment lists at monthly or other intervals.
14. What percentage of the contracts for California health care services that you or your medical groups and IPAs have with Commercial HMOs and/or POS plans includes the sharing of risk through the establishment of risk pools?
15. For the summary of transactions against the risk pools related to contracts identified in Question 14, what proportion of summaries do the health plans send directly to the following entities: PPMC, foundation, MSO; IPAs; medical groups?
16. For those summaries of transactions against risk pools that you receive directly, please indicate the percentage of the summaries that you receive monthly, quarterly, and annually from commercial HMOs and/or POSs.
17. For risk pool distributions you **received** during the past 12 months, please indicate the percentage distributed to you within the following time periods after the close of the applicable risk pool year for commercial HMO and/or POS plans: within 3 months, between 3 and 6 months, between 6 and 9 months, between 9 and 12 months, more than 12 months.
18. For risk pool distributions that you **received** during the last 12 months, what percentage of the distributions did you contest for commercial HMO and/or POS plans?

19. During calendar year 1998, did you experience delayed payments from health plans on fee-for-service claims? If yes, how often did this occur: always, usually, sometimes, rarely? If you do not submit claims to health plans, please go to Question 31.
20. During calendar year 1998, did you experience instances when health plans paid fee-for-service claims at a lower amount than the contracted rate? If yes, how often did this occur: always, usually, sometimes, rarely?
21. Do you have the capability to send claims electronically to the health plans with which you contract? If yes, what percentage of claims do you send electronically?
22. Do you track the length of time it takes for claims you submit to be paid? If asked by the Bureau of State Audits, could you provide documentation of the tracking of specific claims?
23. For calendar year 1998, please indicate the range of days after billing uncontested claims that you received payment from the top three (on the basis of gross revenue) commercial HMOs, PPOs, and other entities (such as POSs, EPOs, or indemnity companies) with which you contract: 30 days or less, 30 to 45 days, 45 to 60 days, over 60 days, do not track this information.
24. For calendar year 1998, please indicate how often, if at all, you experienced having to resubmit claims to commercial HMO plans, POS plans, PPO plans, EPO plans, indemnity plans: never, rarely, sometimes, usually, always.
25. For calendar year 1998, please indicate the percentage of the claims you submitted that the following entities contested and/or denied: commercial HMO plans, POS plans, PPO plans, EPO plans, commercial indemnity plans.
26. For calendar year 1998, please rank from 1 to 10, with 1 being the most frequent reason and 10 the least frequent, the reasons given by commercial HMO plans, POS plans, PPO plans, EPO plans, and/or commercial indemnity plans

for contesting or denying claims you submitted: beneficiary not eligible; service not medically necessary; service not a covered benefit; services provided do not match services authorized; required preauthorization not obtained; claim incomplete; claim previously denied; claim not filed within filing limits; duplicate claim; other.

27. In your experience during calendar year 1998, were there claims for particular kinds of services or specialties that payers were less likely to process within 30 to 45 days? Please name these services or specialties.
28. Do you track claims for which you received payment that was less than the contracted rate (or downcoded)?
29. During calendar year 1998, what was the percentage of claims for which you received payment at a lower amount than the contracted rate for commercial HMOs, POS plans, PPO plans, EPO plans, and/or commercial indemnity plans?
30. For calendar year 1998, please rank from 1 to 5, with 1 being the most frequent reason and 5 the least frequent, the reasons given by commercial HMOs, POS plans, PPO plans, EPO plans and/or commercial indemnity plans for paying a lower amount than the contracted rate on claims you submitted: service code combinations bundled and paid differently than billed; change in payment rates; others.
31. For calendar year 1998, please indicate the proportion of difficulty you experienced with obtaining information from commercial HMO plans, POS plans, PPO plans, and/or other health plans, (specify). that affected the timing of your receiving claims or capitation payments: very difficult, somewhat difficult, no difficulties, not applicable.
32. How frequently do the organizations that pay you include interest on delayed payments (capitation, fee-for-service, or both): commercial HMO plans; other health plans, (specify)?



33. For payment-related complaints that you had with health plans, did you use the dispute resolution processes set up by the health plans to resolve the complaint or problem? If yes, what was your opinion of the dispute resolution process: complaint settled (resolution was fair to both us and the health plan); complaint settled (process was more trouble than it was worth); complaint settled (resolution was not fair to us); dispute still in process?
34. For claims that you process and pay, do you require the use of the HCFA 1500 or similar form as the major element of the claims package?
35. Do you have the capability of accepting claims electronically? If yes, what percentage of claims do you receive electronically?
36. Over the next two years, do you expect to increase the percentage of claims you receive electronically: no; yes, substantially; yes, minimally.
37. Do you track the length of time it takes you to process claims? If asked by the Bureau of State Audits, could you provide documentation of your process?
38. What is the range of time it takes you to pay claims that are not invalid, incomplete or otherwise contested: less than 30 days, 30 to 45 days, 45 to 60 days, more than 60 days?
39. What percentage of claims do you pay electronically or with hard-copy checks.
40. For calendar year 1998, what percentage of the claims that you **received** and processed fell into the following categories: paid within 45 days; delayed more than 45 days, claim ruled incomplete; denied, beneficiary not eligible; denied, not a covered benefit; denied, not medically necessary?
41. For calendar year 1998, please rank from 1 to 10, with 1 being the most frequent reason and 10 the least frequent, the reasons you gave for contesting or denying claims that you received for payment: beneficiary not eligible; service

not medically necessary; service not a covered benefit; services provided do not match services authorized; required preauthorization not obtained; claim incomplete; claim previously denied; claim not filed within filing limits; duplicate claim; other (specify).

42. During calendar year 1998, what percentage of claims did you pay at a lower amount than the contracted rate?
43. For calendar year 1998, please rank from 1 to 5, with 1 being the most frequent reason and 5 the least frequent, the reasons you gave for paying a lower amount than the contracted rate on claims that you processed and paid: service code combinations bundled and paid differently than billed; change in payment rates; other (specify).
44. For calendar year 1998, please indicate the proportion of difficulty (very difficult; somewhat difficult; no difficulties) you experienced with obtaining information from each type of entity that affected the timing of your paying claims: specialist physicians with whom you contract; physicians in medical groups and IPAs that contract for administrative services; health plans.
45. During calendar year 1998, what were the five most frequent claims-related complaints you received from the medical groups and IPAs with which you contract?
46. Have you established a process to resolve payment disputes with physicians? If yes, how extensively is it used: never, rarely, sometimes, frequently, extensively?
47. In your experience, to what extent do you agree with the following statements: HMOs cause delayed payments; POSs cause delayed payments; PPOs cause delayed payments; EPOs cause delayed payments; indemnity plans cause delayed payments: strongly agree, somewhat agree; somewhat disagree or strongly disagree?
48. If asked by the Bureau of State Audits, could you provide actual examples of late payments by payers for capitated payments, claims payments, and/or risk pool distributions?

49. During calendar year 1998, how much utilization review did you perform on the services rendered by physicians in medical groups or IPAs of which you own the assets, specialist physicians with whom you contract, physicians within medical groups or IPAs with which you contract but do not own assets: none, little, moderate, extensive?

## SURVEY OF HEALTH CARE PLANS

1. For calendar year 1998, what percentage of your California gross revenue was in the following lines of business: commercial HMO (non-Medicare, non-Medi-Cal); Medicare/Medi-Cal HMO; point of service plan (POS); preferred provider organization (PPO); exclusive provider organization (EPO); commercial indemnity; other (total should equal 100 percent)?
2. During calendar year 1998, in each product line—commercial HMO; POS; PPO; EPO; commercial indemnity—with how many organizations did you contract: IPAs<sup>14</sup>, medical groups<sup>15</sup>, individual medical doctors, acute care hospitals?
3. How frequently do you update your internal enrollment lists for the number of enrollees—commercial HMO, POS, PPO, EPO, commercial indemnity—including demographics: daily; weekly; monthly; other (specify)?
4. How frequently do you provide updated enrollment lists to IPAs and medical groups with which you contract for commercial HMOs and/or POSs: monthly; quarterly; other (specify)?
5. With how many of the organizations with which you contract as identified in Question 2 do you share risk through the use of risk pools for commercial HMOs and/or POSs: IPAs; medical groups; acute-care hospitals?

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<sup>14</sup>A physician-owned and controlled contracting organization consisting of solo and small groups of physicians that enables the physicians to contract with health plans on a unified basis.

<sup>15</sup>A group of physicians who coordinate their activities in one or more group facilities and who share common overhead expenses; medical records; and professional, technical, and administrative staff.

6. How frequently do you provide a summary of transactions against the risk pool(s) to these organizations for commercial HMOs and/or POSs: monthly; quarterly; annually?
7. For risk pool distributions that you made during calendar year 1998, what percentage of risk pool payments did you distribute within 3 months, between 3 and 6 months, between 6 and 9 months, between 9 and 12 months, and more than 12 months after the close of the applicable risk pool year for IPAs; medical groups; acute-care hospitals?
8. For risk pool distributions that you made during calendar year 1998, what percentage of the total number of risk pool distributions was contested for IPAs; medical groups; acute-care hospitals?
9. For your commercial HMO line of business, what is your capitation payment cycle: quarterly; bi-monthly; monthly; other (specify)?
10. For your commercial HMO line of business, when do you include a new enrollee in the capitation payment: upon enrollment; when enrollee first uses services? If asked by the Bureau of State Audits, could you provide documentation of the process you use to add new enrollees to the capitation payment?
11. For your commercial HMO line of business, do you send enrollment lists to the IPAs and medical groups with which you contract at the same time as the capitation payments?
12. For your commercial HMO line of business, do you send information on the risk factor data used to calculate capitation payment to the IPAs and medical groups with which you contract? If yes, how frequently do you send this information: quarterly; bi-monthly; monthly; other (specify)?
13. For your commercial HMO line of business, do you pay capitation payments electronically? If yes, what percentage of capitation payments do you pay electronically?

14. Do you require the use of the HCFA 1500 form as the major element of a claims package?
15. Do you have the capability of accepting claims electronically? If yes, what percentage of claims do you receive electronically?
16. Do you track the length of time it takes you to process claims? If asked by the Bureau of State Audits, could you provide documentation of the tracking of specific claims?
17. For calendar year 1998, what was your average number of days to pay claims: commercial HMO; POS; PPO; EPO; commercial indemnity?
18. How do you pay claims for commercial HMO, POS, PPO, EPO, commercial indemnity plan: electronically; hard-copy check?
19. During calendar year 1998, for your commercial HMO line of business, what percentage of the claims you received and were responsible for paying were paid within 45 days; delayed more than 45 days, claim ruled incomplete; denied, not a covered benefit; denied, not medically necessary (each category should total 100 percent) for: IPAs; medical groups; individual medical doctors; acute-care hospitals?
20. For calendar year 1998, for your POS line of business, what percentage of the claims you received were paid within 30 days; delayed more than 30 days, claim ruled incomplete; denied, not a covered benefit; denied, not medically necessary (each category should total 100 percent) for: medical groups; individual medical doctors; acute-care hospitals?
21. For calendar year 1998, for your PPO line of business, what percentage of the claims you received were paid within 30 days; delayed more than 30 days, claim ruled incomplete; denied, not a covered benefit; denied, not medically necessary (each category should total 100 percent) for: medical groups; individual medical doctors; acute-care hospitals?

22. For calendar year 1998, for your EPO line of business, what percentage of the claims you received were paid within 30 days; delayed more than 30 days, claim ruled incomplete; denied, not a covered benefit; denied, not medically necessary (each category should total 100 percent) for: medical groups; individual medical doctors; acute-care hospitals? If you do not sell this product, go to Question 23.
23. For calendar year 1998, for your commercial indemnity line of business, what percentage of the claims you received were paid within 30 days; delayed more than 30 days, claim ruled incomplete; denied, not a covered benefit; denied, not medically necessary (each category should total 100 percent) for: medical groups; individual medical doctors; acute-care hospitals? If you do not sell this product, go to Question 24.
24. For calendar year 1998, please rank from 1 to 10, with 1 being the most frequent reason and 10 the least frequent, the reasons you contested and/or denied claims submitted by IPAs, medical groups, and individual physicians for commercial HMO, POS, PPO, EPO, commercial indemnity plans: beneficiary not eligible; service not medically necessary; service not a covered benefit; services provided do not match services authorized; required preauthorization not obtained; claim incomplete; claim previously denied; claim not filed within filing limits; duplicate claim; other (specify)?
25. If asked by the Bureau of State Audits, could you provide documentation of the tracking of specific claims you contested and/or denied?
26. For any claims you processed during calendar year 1998, were there claims for particular kinds of services or specialties, other than services provided by hospitals, that you were responsible for paying, but were less likely to process with 30 to 45 days? Please name these services or specialties.
27. During calendar year 1998, what percentage of claims did you pay at a lower amount than the contracted rate for commercial HMO, POS, PPO, EPO, commercial indemnity plans: IPAs; medical groups; individual medical doctors; acute-care hospitals?

28. For calendar year 1998, please rank from 1 to 5, with 1 being the most frequent reason and 5 the least frequent, the reasons you gave for paying a lower amount than the contracted rate on claims submitted by IPAs, medical groups, and individual physicians for commercial HMO, POS, PPO, EPO, commercial indemnity plans: service code combinations bundled differently than billed; change in payment rates; others (specify)?
29. For calendar year 1998, please indicate the percentages of IPAs, medical groups, individual medical doctors, acute-care hospitals from which you experienced difficulties with obtaining information that affected the timing of your paying claims: very difficult; somewhat difficult; no difficulties?
30. In your commercial HMO line of business during calendar year 1998, what were the five most frequent capitation-related complaints you received from IPAs and medical groups?
31. In your commercial HMO line of business during calendar year 1998, what were the five most frequent claims-related complaints you received from IPAs and medical groups?
32. In your PPO line of business during calendar year 1998, what were the five most frequent claims-related complaints you received from medical groups and individual medical doctors?
33. In your POS line of business during calendar year 1998, what were the five most frequent claims-related complaints you received from medical groups and individual medical doctors?
34. For your commercial HMO line of business during calendar year 1998, what percentage of utilization review did you delegate to an IPA or medical group?
35. In your commercial HMO line of business during calendar year 1998, how much utilization review did you directly perform on the services provided by the entities with which you contract—IPAs, medical groups, individual medical doctors, acute-care hospitals: none; little, moderate, extensive?

36. In your POS line of business during calendar year 1998, how much utilization review did you directly perform on the services provided by the entities with which you contract—medical groups, individual medical doctors, acute-care hospitals: none; little; moderate; extensive?
37. In your PPO line of business during calendar year 1998, how much utilization review did you directly perform on the services provided by the entities with which you contract—medical groups, individual medical doctors, acute-care hospitals: none; little; moderate; extensive?
38. In your commercial HMO line of business, do you monitor the financial stability of the IPAs and medical groups with which you contract? If yes, how do you do this: desk review of financial statements submitted by the IPAs and medical groups; review of financial documents on-site at the IPAs and medical groups; other (specify)?
39. Please indicate if you are accredited by any of the nationally recognized private, not-for-profit organizations that currently review managed care organizations: Joint Commission on Accreditation of Healthcare Organizations; American Accreditation HealthCare Commission; National Committee for Quality Assurance; Accreditation Association for Ambulatory Health Care?