California Health Care Foundation

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Issue Brief

As Commercial Capitation Sinks, Can California's Physician Organizations Stay Afloat?

A study in *Health Affairs* raised alarm bells in health policy circles recently when the researchers presented new evidence that capitation — fixed prepayment for care of a defined population — is declining, and that fee-for-service (FFS) is increasing nationwide.[1] Concern about disappearing capitation in California dates back to at least 2009, when Ginsburg and colleagues first called it out.[2] But having heard from many stakeholders throughout the state that the problem is accelerating — particularly for commercial payers — the California Health Care Foundation decided to take a fresh look at the issue.

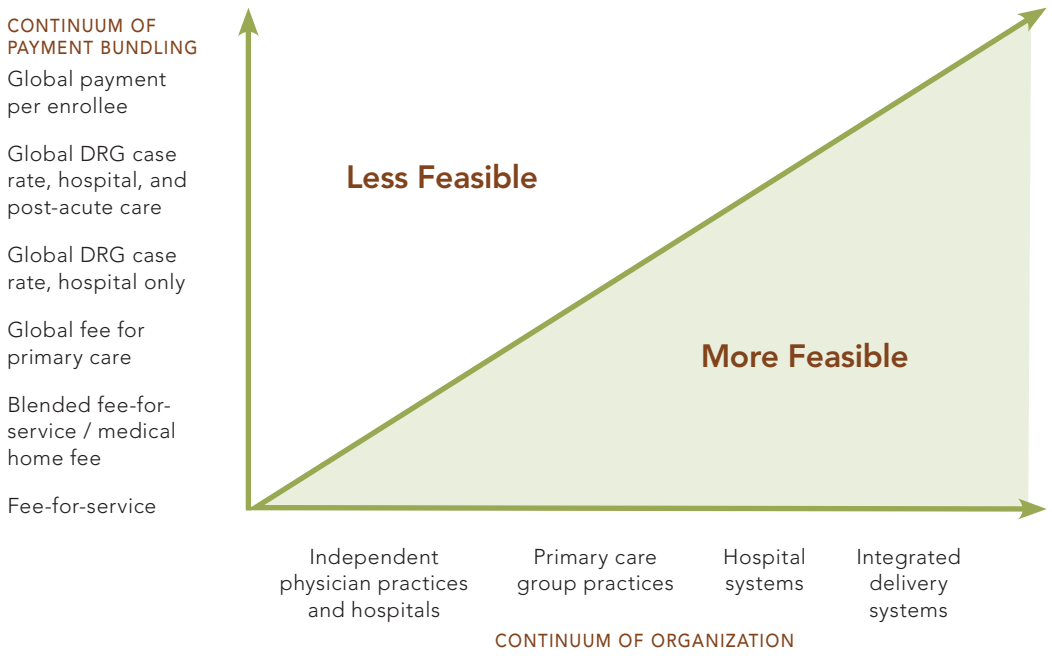
Background

Capitation has long played an important role in California. The state leads the nation both in penetration of large, integrated, multispecialty physician organizations and in use of the capitated, delegated model, in which utilization and care management responsibilities are delegated to capitated physician organizations.

In such arrangements, capitation and integrated delivery systems are inextricably linked. The Commonwealth Fund's Commission on a High Performance Health System found that integrated delivery systems are better equipped than less-integrated providers to take on advanced value-based payment systems, and conversely, such payment systems are needed to support integrated delivery systems (see Figure 1 on page 2).[3] Yegian and colleagues noted some benefits of the approach in a recent blog post: "The delegated-HMO [health maintenance organization] model — resting on a strong foundation of integrated care delivery — is a major reason that California is ahead of the curve on value-based payment to advance the triple aim of better care, better health, and smarter spending."[4]

As health care stakeholders demand greater accountability, coordination, and integration from the delivery system, there is increasing focus on payment as a means of delivery system reform. Several prominent organizations have set goals around the proportion of health care payments that should be value-based in the near future.[5] Many types of payments can be considered value-based, including bundling, shared savings, shared risk, pay-for-performance, and others. However, capitation can be an especially powerful enabler of delivery system integration and improvement, providing it is combined with quality incentives.

Figure 1. Health Care Organization and Payment Methods



Note: *DRG* is diagnosis-related group.

Source: *The Path to a High Performance US Health System*, The Commonwealth Fund Commission on a High Performance Health System, February 2009. (Adapted by CHCF for this publication.)

The Research

This project sought to quantify the extent to which commercial capitation is declining in California, and to understand the impact such a trend might have on the state's physician organizations — medical groups and independent practice associations (IPAs). The main question at hand is whether California's delegated model will remain sustainable with lower levels of commercial capitation.

The analysis is based on both quantitative and qualitative information. Because few data on capitation are available, the author relied on a number of proxies. The quantitative inquiry was supplemented by interviews with several of California's medical group and IPA leaders (see the Appendix for a list of interviewees). This issue brief describes the findings of this inquiry and offers some insights and perspectives about the future of California's physician organizations.

Why the Concern?

To invest in the infrastructure necessary to care for an enrolled population, California's physician organizations have traditionally relied on some amount of prepayment. However, it is not clear exactly what proportion of a physician organization's revenue needs to be prepaid to allow them to make these investments. In a 2009 report, Ginsburg and colleagues observed that "as the percentage of patients covered under the delegated model diminishes, it becomes less compelling for a practice to invest the resources needed to manage [care and costs]."[6]

Most of California's delegated medical groups serve both HMO (theoretically prepaid) and PPO[7] (FFS) patients. The groups consulted for this analysis reported that the care management systems they put in place for the HMO patients are used for all patients. But is there a tipping point at which the amount of HMO capitation/prepayment becomes insufficient to support the infrastructure for all patients? In that case, would organizations have to downsize this infrastructure, or eliminate it? Importantly, would they begin to treat prepaid patients differently from FFS patients in terms of doctors' clinical decisions? In the case of IPAs, which cannot serve FFS patients due to regulatory restrictions, is there simply a point at which the amount of prepayment is insufficient to support ongoing operations?

Is there a tipping point at which the amount of HMO capitation/prepayment becomes insufficient to support the infrastructure for all patients?

It should be noted that some California health plans that look like traditional, delegated model HMOs on the outside do not actually capitate their contracted physician organizations. While such a disconnect between HMO and capitation is relatively novel in California, it is consistent with national trends. In their recent paper documenting a decline in capitation, Zuvekas and Cohen noted that in the US, capitation has "declined substantially for people enrolled in private or Medicaid . . . HMOs."[8] Capitation was the form of payment for around 18% of visits for private HMO patients in 2013, and just over 8% of visits for Medicaid HMO patients in the same year, compared to 35% and 25%, respectively, in 1996.

What Factors Might Cause a Decline?

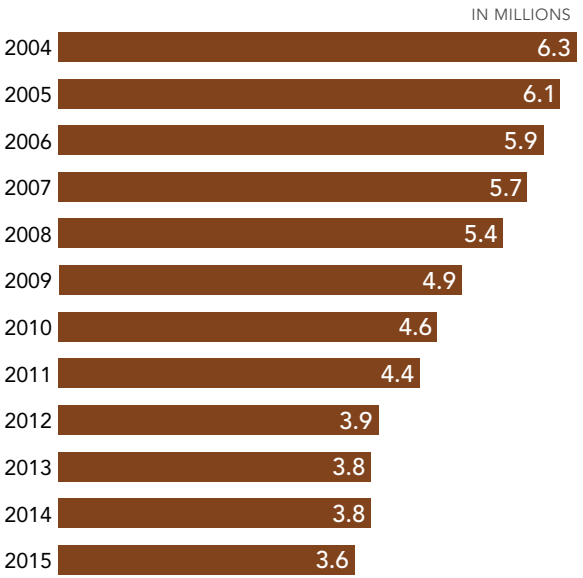
To the extent that there has been a decline in commercial capitation in California, one would expect to see it precipitated by either or both of two trends: declining commercial HMO enrollment, and increasing cost-sharing (high deductibles) within HMO products.

Shrinking Commercial HMO Enrollment

California's commercial HMO population has shrunk drastically in the last 10 years. According to the California Department of Managed Health Care (which regulates the state's HMOs), in 2015 the commercial HMO market was 9.8 million strong; this includes 8.9 million group enrollees and 0.9 million individual (nongroup) enrollees.[9] As a reference point, California's entire commercially insured population that year was about 14.1 million.[10]

Of the 9.8 million commercial HMO enrollees in 2015, about 6.1 million were Kaiser Permanente ("Kaiser") enrollees, who received care exclusively through the two Permanente Medical Groups in Northern and Southern California. As a result, there were about 3.6 million commercial HMO enrollees for all of the non-Permanente physician organizations in the state. As illustrated in Figure 2, non-Kaiser commercial HMO enrollment plummeted in the last decade, from 6.3 million in 2004 to the current 3.6 million — a loss of more than 40%.

Figure 2. California Commercial HMO Enrollment, Excluding Kaiser, 2004 to 2015



Source: California Health Care Foundation analysis of California Department of Managed Health Care enrollment reporting.

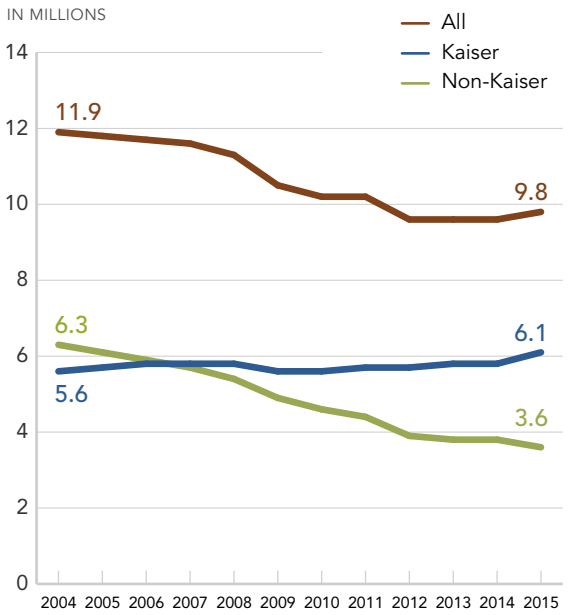
Kaiser is excluded from the above analysis because of the mutually exclusive relationship between the health plan (Kaiser Foundation Health Plan) and its two associated medical groups. While Kaiser is by far the largest HMO in California (and growing), the health plan offers capitated contracts *only* to its affiliated Permanente Medical Groups. As a result, high Kaiser enrollment numbers cannot be equated with ready availability of capitated contracts for the rest of California's physician organizations (quite the opposite, in fact, as discussed below).

See www.chcf.org/HMOenrollment for more data on HMOs.

There are several possible reasons for the decline in non-Kaiser commercial HMO enrollment. First, the recession has likely caused employers to move from richer HMOs (with fixed-dollar cost-sharing) to more affordable PPOs (with larger co-insurance and deductibles) or to self-insured arrangements. This is certainly the perception among stakeholders interviewed for this project. However, empirical evidence of such trends is limited, as California regulators did not start reporting data on PPO and self-insured enrollment until 2012. In fact, according to employer survey data, non-HMO enrollment (PPOs, POSs, and high-deductible health plans with a savings option) actually *decreased* between 2007 and 2015, dropping from 52% to 44% of covered workers in California.[11] Employer survey data also reveal that between 2009 and 2015, there was an increase in self-insurance of only one percentage point, from 31% to 32% of covered workers.[12]

Second, it is likely that some HMO enrollment has migrated to Kaiser from other commercial plans (and their capitated provider organizations). Between 2004 and 2015, while the size of the overall commercial HMO market (including Kaiser) declined, Kaiser's commercial HMO enrollment rose from 5.6 million to 6.1 million, or from 47% to 63% of the entire commercial HMO market (Figure 3).

Figure 3. California Commercial HMO Enrollment, Kaiser vs. Non-Kaiser, 2004 to 2015



Source: California Health Care Foundation analysis of California Department of Managed Health Care enrollment reporting.

In a 2014 paper on the decline of the delegated model, Yegian and Williams put forth an additional explanation for the trend. Stakeholders they interviewed cited a lack of data transparency as a major driver.[13] Traditionally, physician organizations under the delegated model have not been able to produce the kind of granular data on claims and utilization that many payers want. Some of the stakeholders interviewed for this analysis also mentioned the lack of data transparency, but in the context of risk adjustment, saying that capitated physician organizations have been unable to provide health plans with timely data to support diagnosis-based risk adjustment.

HMO Deductibles and Covered California

Another factor contributing to declining commercial capitation could be the rise of deductibles in HMO products. Capitation is essentially a payment by the health plan to the provider for most or all the costs a patient is expected to incur in a given time period. However, when a health plan shifts responsibility for a large portion of those costs onto the patient, there is, at least in theory, less money available for the plan to pay the provider up front. Some of the stakeholders interviewed for this project reported that, particularly in Covered California (the state's health benefit exchange), deductibles have become so high that plans no longer see the benefit of capitating providers, even under HMO benefit designs.

Today, about 1.4 million people are enrolled in Covered California, with just under 90% eligible for a premium subsidy and about half eligible for a cost-sharing subsidy (which reduces the deductible).[14] Even with the cost-sharing subsidies in play, about half of Covered California enrollees have a deductible of $1,900 or more, which can be considered a high-deductible plan.[15] Among the approximately 650,000 HMO enrollees in Covered California, 28% (all of whom are enrolled in either bronze-level or catastrophic coverage) have an individual deductible of $4,500 or more; 40% have a deductible of $2,250 or more; and just under 50% have a deductible of $1,900 or more (Table 1, page 5).[16]

According to one expert interviewed for this project, Blue Shield of California (the largest insurer in the exchange by number of lives in 2016)[17] engages in no capitated contracting with physician organizations for its Covered California plans; all products, even HMOs, pay provider organizations on an FFS basis. Other stakeholders reported that HealthNet (the fourth-largest insurer in the exchange) uses a hybrid HMO capitation contract in Covered California — FFS contracts with individual physicians and a per-member, per-month care management fee for the medical group or IPA.

Several stakeholders said that the lack of capitation in Covered California is related to physician organizations' inability to track patient spending to determine when a deductible has been met. Technology to solve this problem is often referred to as an "accumulator." There was some disagreement about the nature of this problem, however. CAPG, representing the capitated medical groups and IPAs, has noted that physicians will be unable to track patient spending in near-real-time until stakeholders in the market collectively develop a "standardized, all plan, all provider encounter data clearinghouse, with a standardized portal for encounter data reporting . . . and a standard 'deductible accumulator.'"[18]

Table 1. Distribution of Individual Deductibles in Covered California HMO Products, 2016

DEDUCTIBLE*	ENROLLEES WITH DEDUCTIBLE AT... THIS LEVEL	THIS LEVEL OR HIGHER	COMMENTS ON METAL LEVELS WITH THIS DEDUCTIBLE LEVEL†
$4,500+	28.1%	28.1%	Bronze, bronze health savings account (HSA), and catastrophic coverage
$2,250	11.9%	40.0%	Enrollees with silver coverage and incomes of >250% FPL
$1,900	9.2%	49.1%	Silver 73 (cost-sharing reductions for silver enrollees at 201%-250% FPL)
$550	26.6%	75.7%	Silver 87 (cost-sharing reductions for silver enrollees at 151%-200% FPL)
$75	14.7%	90.4%	Silver 94 (cost-sharing reductions for silver enrollees at 139%-150% FPL)
$0	9.6%	100.0%	Gold or platinum

*Family deductibles are twice individual deductibles.

†Under all metal levels, preventive care is free. For silver plans, all primary care office visits are exempt from the deductible (copays apply); for bronze and catastrophic plans, the first three primary care office visits are exempt from the deductible (copays apply).

Source: Covered California Active Member Profile, March 2016.

CAPG is spearheading work to achieve stakeholder alignment around an accumulator that is interoperable across physician organizations and plans. However, some of the groups and IPAs interviewed for this analysis said that the "accumulator problem" had not been an issue in their own dealings with health plans in Covered California. Stakeholders on both sides of the issue suggested that the problem may be something of a red herring, intended to divert attention from other reasons that health plans might not want to capitate physician organizations, or that such organizations might not want to accept the offered conditions of capitation.

Obscuring the potential impact of Covered California's high deductibles on physician organizations is the fact that under all metal tiers, at least some primary care is exempt from the deductible, and in many plans may be free, or nearly so. According to a recent article by Lee and Fisher, this benefit design is intended to prevent patients from foregoing needed care.[19] It may also result in slightly more prepaid revenue for physician organizations than would otherwise be suggested by such large deductibles.

Ultimately, however, it is unlikely that the dynamics within Covered California have had much of an impact on California's capitated, delegated model. Forty-seven percent of the exchange's 1.4 million enrollees are in HMOs, with Kaiser accounting for 328,000 of those.[20] This brings the exchange's non-Kaiser HMO enrollment down to about 277,000, or just under 8% of the 3.6 million total non-Kaiser commercial HMO enrollees in the state. Eight percent is not insignificant, though; capitation trends in the exchange bear careful watching as possible indicators of things to come in the rest of the commercial HMO market. Importantly, Covered California also sets standards for individual products sold outside of the exchange, so its influence on the market is larger than is apparent from its own enrollment figures alone. That said, the entire individual commercial market remains fairly small, at 16.6% of the total commercial market.[21]

It is also important to look at the presence of deductible plans in the non-exchange group market, where employer surveys are the best source of data. In 2015, 17% of California covered workers enrolled in an HMO had a deductible, with that deductible averaging $1,186.[22] So, while the deductible trend represents a significant portion of the non-exchange group market as well, it does not yet appear that deductibles have reached the ultra-high levels seen in Covered California (or in individual products sold outside of Covered California).

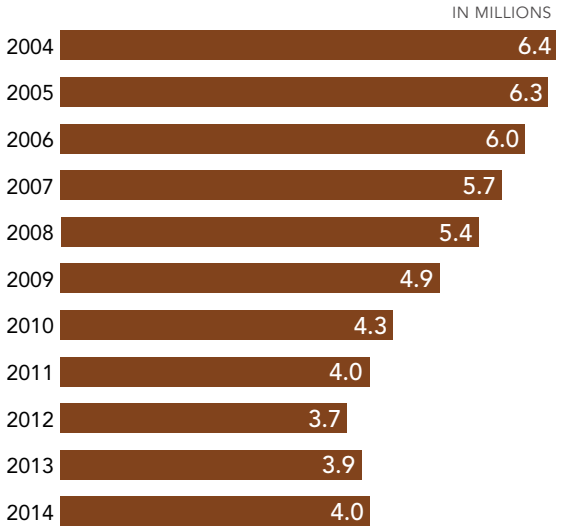
Parsing the Data

Although HMO enrollment trends are a good proxy for capitation trends in the state, they do not tell the whole story; not all HMOs capitate their physician organizations, and that trend may be growing. To fully understand the impact of declining capitation on physician organizations, one would need to track the percentage of groups' revenue that comes from commercial, Medicare, and Medi-Cal capitation over time. Unfortunately, no such data are available, but two other data sources may help flesh out the picture of California's commercial capitation trends.

The first is the Medical Expenditure Panel Survey (MEPS) data used by Zuvekas and Cohen in their recent analysis about the decline of capitation nationally.[23] The MEPS Medical Provider Component is not designed to produce state-level estimates, but for a state as large as California, it is possible to do so. Zuvekas reported to the author that in California in 2003, the estimated proportion of patient visits that were capitated or prepaid was 32%, and in 2013, the number had dropped to 26%.[24] However, the confidence intervals around both of those estimates are so large (0.27 to 0.37 and 0.20 to 0.32, respectively) that they could actually represent no drop at all, or even an increase.

The second source of data is California's Department of Managed Health Care (DMHC). As part of their annual financial reports to DMHC, managed care plans must self-report the number of covered lives for which they capitate "risk-bearing organizations" (RBOs) — medical groups or IPAs that do not themselves have a managed care license (see Section 1375.4[g] of California's Knox-Keene Act for a more technical definition of RBOs[25]). As shown in Figure 4, commercial capitated RBO enrollment has consistently fallen, from a high of 6.4 million in 2004 to just about 4.0 million in 2014. Importantly, these numbers do not include Kaiser enrollees, as the Permanente Medical Groups are not considered RBOs.

Figure 4. Commercial Capitated RBO Enrollment, California, 2004 to 2014



Source: California Department of Managed Care Health, Health Plan Annual Survey Reports, 2004 to 2014.

Notably, the trend lines based on the non-Kaiser commercial HMO enrollment data (Figure 2) and the RBO data are quite similar. Differences between the two data sets are likely due to the vagaries of self-reporting, including different interpretations of statutory definitions and double-counting due to sub-capitation, among other issues. However, at the 2004 and 2014/2015 endpoints, the HMO enrollment figures are 6.3 million and 3.6 million, while the RBO figures are 6.4 million and 4.0 million. The alignment between the two data sets provides further evidence that commercial capitation has dropped steadily since 2004, losing at least a third of enrollees.

As noted earlier, using national MEPS data, Zuvekas and Cohen detected a decline in capitation even under commercial HMO products. In California, if there is a similar trend, one should begin to see a divergence between the HMO and RBO data sets, with the RBO numbers dropping below the HMO enrollment totals. It will therefore be worthwhile to continue to monitor both data sources going forward.

What Are Medical Group and IPA Leaders Saying?

To get a fuller picture of the impact of declining commercial capitation, this project included a series of semi-structured interviews with the leaders of three California medical groups and three IPAs selected for geographic diversity and their relatively large size; they are not in any way representative of all groups or IPAs in the state. The interview responses can be distilled into several themes:

There is uncertainty about the near future. Medical group and IPA leaders reported that declining commercial capitation has not yet had a big impact on their operations, but they suspect that it may soon. In general, medical group leaders seemed slightly more concerned about this than did IPA leaders, perhaps because groups are likely to have larger clinical infrastructures that require prepaid support. Notably,

the IPA interviewees represented very large companies with diversified lines of business in addition to their IPAs; smaller IPAs would probably be more concerned about the loss of HMO revenue, which would be their only revenue source.

Change, thus far, has been slow enough that organizations have been able to adapt. Medical group leaders said that most of the HMO patients they "lose" remain with them as PPO patients (an issue that does not apply to IPAs, which cannot accept PPO contracts). They said that as long as this shift from HMO to PPO, or from prepaid to FFS revenue for the same patients, remains fairly slow, they can accommodate it. They can repurpose some of their HMO-based infrastructure (for example, quality measurement and utilization management tools) for value-oriented payment programs that are FFS-based, such as private accountable care organizations.

Groups do not anticipate that declining prepayment will impact clinical decisionmaking. Medical group leaders reported having a strong culture of prevention and disease management linked to a long history of capitation. The interviewees agreed, uniformly, that declining capitation and rising FFS would not influence clinical decisions and that they would not make different clinical decisions for HMO versus PPO patients.

Medicare and Medi-Cal capitation are not viewed as substitutes for commercial capitation. Medical group and IPA leaders noted that although commercial capitation has declined, they are seeing many more opportunities to accept capitation under Medicare Advantage (MA) and Medi-Cal managed care. Some see MA, in particular, as the primary driver of their recent growth and/or that of their competitors, with large amounts of funds at stake and rewards for efficiency. While the perception is that MA capitation rates are generous, there was also recognition that these patients are costly. As a result, growing MA capitation does not necessarily compensate for lost commercial capitation, unless the provider organization is especially skilled at managing care for older patients.

Further, interviewees generally perceived Medi-Cal capitation rates as inadequate; some said the rates do not cover their costs. Others said that because they are not Federally Qualified Health Centers and therefore cannot access state-funded wraparound payments to supplement capitation rates, their participation in Medi-Cal managed care will have to remain limited.[26]

Additional barriers to increased Medi-Cal managed care participation included: quality measurement inconsistent with that used by most commercial plans in California; rate volatility due to frequent changes in state budgets and in federal Medicaid policy; and private physician organizations' relative lack of experience in treating the Medi-Cal population, with its high burden of nonmedical, psychosocial needs.

There is a lot of concern about the impact of high-deductible health plans on patients. Interviewees were split on whether high deductibles are related, or contribute, to declining capitation; however, they were unanimous in their concern about the possible impact of such plans on patients. Specifically, they fear that patients will not obtain the care recommended by their providers because of high out-of-pocket costs. While one or two leaders said they are already seeing this happen frequently, others said it is more of a concern for the future. Some also said they had seen an increase in bad debt, as patients obtain care but are unable to pay their cost-sharing after the fact.

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There is no consensus about Covered California. Some of the groups and IPAs expressed frustration with the lack of capitated health plan contracts under Covered California. Others said they did not perceive this as a problem, or had not experienced it themselves.

What to Watch

This analysis confirms that non-Kaiser commercial capitation has declined significantly in California in the last 10 years. However, the implications of that finding are not yet clear. It is important to continue to monitor the marketplace, watch for new developments, and dig deeper into several issues. Four such issues are discussed below.

The Development of Data

To truly quantify the financial impact of declining capitation on medical groups, one would need information about the percentage of revenue that groups receive from prepayment. Such information

could likely only be obtained through a survey, which might be a next step in this inquiry. In addition, the National Association of Insurance Commissioner's System of Electronic Rate and Form Filing (SERFF) could be a promising source for tracking the dollar volume of capitation in California and the nation going forward.[27] Although the SERFF's historical data (pre-2011) are not robust enough to support an accurate look back like the one presented here with DMHC data, it is now used by both the DMHC and the California Department of Insurance and by regulators in 48 other states and the District of Columbia.

New Forms of Commercial Prepayment

Before the alarm is raised about the disappearance of commercial capitation, it must be asked whether some other type of prepayment may take its place. Under the auspices of the Center for Medicare and Medicaid Innovation, public and private payers around the country are experimenting with new payment designs, some of which involve commercial prepayment. One such program is Comprehensive Primary Care Plus, a five-year model that will start in January 2017.[28] Under this program, regional multipayer coalitions will pay providers a monthly management fee of about $30 per patient. For evaluation and management services, providers will also receive a portion of the expected reimbursements in advance, with the remainder paid through reduced fee-for-service payments after the services are rendered.[29]

Private Versus Public Providers

Another development that bears watching is the changing role of private versus public providers in California. Although California's commercial capitation has supported the proliferation of robust private medical groups and IPAs in the past, much of today's potential for capitation growth appears to be in Medi-Cal managed care, where enrollment increased from 4.7 million to 10.3 million between 2004 and 2015 (although it is not clear how much of this enrollment is capitated at the provider organization level).[30]

If, as suggested by this project's interviews, private physician organizations are reluctant to enter the Medi-Cal capitated market (for a variety of reasons), it is likely that other providers will step in to take advantage of what many see as the benefits of capitation. Networks based on community clinics and public providers are already becoming more prominent in managed care markets. Today, over 22% of medical groups in California accepting risk contracts directly from HMOs are either community clinics, county groups, or University of California (UC) providers; the rest are private group practices (including the two Permanente Medical Groups) or IPAs. In contrast, the corresponding figure from 2006 was just over 15% community clinics / county groups / UC.[31] Will these dynamics further the longstanding divide between the public and private health care systems in the state?

Much of today's potential for capitation growth appears to be in Medi-Cal managed care.

The Kaiser Trajectory

Finally, while non-Permanente provider organizations experienced a drastic reduction in commercial capitated enrollment over the last decade, Kaiser has grown. In fact, a large proportion of that growth has been in high-deductible HMOs. Kaiser sources reported that, since 2010, their traditional commercial HMO business in California (copay-only, no deductible) has declined by 1%, while their deductible-HMO business has increased by 127%, and their HSA-compatible HMO business by 40%.[32]

To succeed with these HMO product types, the organization solved several problems that appear to stymie some of the provider groups in the state: tracking deductibles and collecting patient cost-sharing. As is the case for other physician organizations, these capabilities were not traditionally part of the Permanente Medical Groups' core competencies; the medical groups and their partner health plans have had to invest significant resources in data, documentation, and systems to track discrete units of care, assign prices to them, and bill patients for their share.

This work may have been easier for the Permanente Medical Groups than for many California physician organizations for several reasons:

1. The sheer size of the Permanente Medical Groups and the all-inclusiveness of the specialties represented mean that patients almost always see *only* Permanente doctors. Therefore, the group does not have to track utilization and spending from outside providers, as do many smaller physician organizations that may not have the wide range of specialists and sub-specialists.

2. All of the Permanente physicians share a comprehensive electronic health record, which provides a ready platform to create systems for tracking patients' utilization and costs.
3. Because of their close and exclusive relationship with the Kaiser Foundation Health Plans, the Permanente groups have access to significant administrative resources and expertise to support them in what are essentially insurance functions.

Thus, the commercial HMO model works well for Kaiser, but perhaps it will not continue to do so for the state's non-Permanente physician organizations. It is unclear whether there will be any capitated business left for these groups in the near future, given the difficulties they report in contracting with Medi-Cal managed care organizations and the rapidly shrinking non-Kaiser commercial HMO market. It is possible that private provider organizations will need to seek other ways to serve the commercial population — for example, by working with legislators and regulators to design a feasible method for accepting capitation from self-insured employers.

Conclusion

It could be argued that if private physician organizations cannot adapt to the changing payment landscape, their demise would be a natural consequence of market forces and would not require intervention. However, California's capitated, delegated physician organizations have a long history and significant expertise in managing risk and coordinating care — the very skills that health care purchasers are demanding from the delivery system. A growing body of evidence bolsters the case for maximizing the likelihood that these organizations will survive.

For example, researchers associated with the *Dartmouth Atlas* examined the cost and quality of care provided to Medicare beneficiaries by physicians who did and did not work within large multispecialty group practices affiliated with the Council of Accountable Physician Practices.[33] Among these practices are many of the best-known medical groups in the country, including several of California's delegated provider organizations. The researchers found that "in most markets, and after adjustment for patient factors, group physicians affiliated with the council provided higher-quality care at a 3.6% lower annual cost ($272 per patient)."

More recent evidence from the Integrated Healthcare Association's *Regional Cost and Quality Atlas* indicates that California's delegated physician organizations continue to outperform less organized providers on both cost and quality. That report is the result of a collaboration among 10 of California's largest health plans and is based on claims/encounter and cost data for nearly 75% of Californians enrolled in commercial HMOs and PPOs. Its authors found that commercial HMOs "frequently outperform [commercial] PPOs on both clinical quality and cost measures across the state's 19 geographic regions, reflecting underlying differences between product types, including the use of integrated care delivery systems in HMO provider networks."[34]

It is important to continue tracking the impact of the changing payment environment on California's capitated, delegated physician organizations. As noted by the leaders interviewed for this project, the decline in commercial capitation has been slow enough that it has not yet led to significant changes in their operations; however, it may soon do so. In the meantime, California's health care stakeholders, including patients, payers, and policymakers, should begin a dialogue *now* about the role played by these groups and whether any steps could or should be taken — through policy or payment — to support their continued operation, if not their growth.

About the Author

Laura Tollen is an independent health policy researcher, writer, and editor with over 20 years of experience in national and state health policy. Her primary areas of focus are delivery system organization and payment reform. Prior to establishing her consulting practice, she worked for more than a decade in Kaiser Permanente's Institute for Health Policy.

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

Appendix. Interviewees

Richard Fish
CEO, Brown & Toland Physicians

Steven Green, MD
Chief Medical Officer, Sharp Rees-Stealy Medical Group

Leigh Hutchins, MBA
President and CEO, North American Medical Management California / PrimeCare
COO, OptumCare Southern California

Rich Lipeles, MPH
COO, Heritage Provider Network

Kurt Ransohoff, MD
CEO and Chief Medical Officer, Sansum Clinic

Mark Schafer, MD
CEO, MemorialCare Medical Foundation

Endnotes

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