



Reforming Physician Payments: Lessons from California

Introduction

One point on which many in the current health reform debate agree is that health insurance programs must move away from fee-for-service payment, which rewards service volume and intensity, to a system that encourages providers to achieve the best health outcomes while using resources efficiently.

Much of California's population obtains health care services from organized physician groups that receive comprehensive global payments to provide care for enrolled patients. California's experience with capitation—also known as the “delegated model” since risk is delegated from health plans to provider groups—has several implications for the current national health reform debate:

- For capitation to take hold, formal physician groups and business arrangements must be in place.
- To prevent undesirable outcomes, such as physician group insolvency and stinting on needed care, robust regulatory oversight is required.
- With respect to capitation's potential to improve efficiency and value, California's experience is inconclusive. Documenting its future impact will require more transparent and accountable monitoring than now exists.

This issue brief explores these and related lessons for policymakers seeking to ensure affordability and quality as they pursue a reform agenda.

Capitation in California

In California, how is capitation used, and how prevalent is it? Under capitation, a provider group is paid a fixed amount for each enrolled patient for a defined bundle of services over a span of time, regardless of the amount of care that patient consumes. The prepaid group practice model took root in California with the Kaiser Permanente medical care program, then spread nationally, thanks in part to federal legislation of the 1970s that fostered the concept. Physician groups in many parts of the U.S. experienced problems with capitation and moved away from it starting in the late 1990s, but nearly one-third of the residents of California—in employer-based health plans as well as in Medicare and Medi-Cal (California's Medicaid program)—are covered under capitation payment arrangements today.

The most common capitation approach entails a health plan paying a physician group a set monthly, per-enrollee fee to deliver all professional services, including specialty care and ancillary services such as lab and imaging tests. Some capitation arrangements are more global, such as those that encompass hospital care for enrolled patients, and some are narrower, covering only primary care physicians' services or the services of a single specialty, for example.

Physicians in California generally participate in capitation arrangements in one of two ways. They may be members of formal, multi-specialty group practices in which they share facilities and are salaried, such as the Palo Alto Medical Foundation—a large multi-site clinic which

also has integrated with several other clinics in northern California to contract with health plans jointly. Or they practice solo or in small, single-specialty groups and join networks of independent practitioners or independent practice associations (IPAs) such as Hill Physicians—a northern California network of some 3,000 physicians and other providers. Physicians in IPAs may receive either sub-capitation payment—a slice of the larger IPA capitation designated for the particular specialty or enrollees—or fee-for-service payment. Often, physicians will also be eligible for additional performance incentives tied to meeting goals for quality and efficiency.

In both models, the physician groups negotiate and receive capitated payments from health plans. They are also responsible for financial management and allocation of revenue among the physician members.

What does California’s capitation approach have in common with the federal payment redesign proposals being debated in Congress, and how is it distinctive?

Three concepts found in federal proposals share features with the delegated model in California:

- Payment bundling;
- Accountable care organizations; and
- Medical home.

Bundling is similar in some respects to capitation, though capitation is more all-encompassing. Bundled payments lump together fees for providers involved in designated episodes of care—for instance, combining the surgeon’s and the hospital’s payments for a hip replacement into a single fee that the providers share. Like capitation, bundling aims to counter incentives to provide more services, but only within one care episode. In contrast, capitation payments encompass all episodes throughout an entire enrollment period.

Under bundled payments, providers are still rewarded with more income if they treat more episodes, but they are not rewarded for delivering more services per episode. In contrast, providers under capitation have no incentive to deliver excess services. Rather, their incentive is to ensure that enrollees stay healthy, as well as to attract more enrollees.

The accountable care organization, or ACO, is not yet well defined; however, the concept involves a set of providers, including both primary and specialty care (and possibly acute and long-term care as well) who share incentives to deliver cost-effective care while achieving quality benchmarks. Depending on how ACOs are structured—for example, whether they encompass both outpatient and inpatient care, whether payments are set prospectively for all services, or bonuses are paid for certain outcomes—they may have more or less in common with the delegated model and capitation.

The medical home approach calls for each patient to have a relationship with a designated provider that will create and preserve a complete record of their individual health and health care. This model suggests payments be structured to favor primary care and prevention over complex, interventional care. Proponents of the medical home generally assume that payment will continue to be fee-for-service, though capitation can easily be overlaid on this delivery structure.

Physician groups that have experience with capitation may be relatively well-positioned to receive bundled payments, to participate in ACOs, or to serve as medical homes. In an environment where health plans increasingly offer rewards for meeting quality goals and using referral and hospital services efficiently, medical groups’ experience monitoring and managing service use for a designated set of enrollees could be transferable to a range of new payment arrangements.

What contributed to the expansion of capitation in California? What has limited its growth? Paying physician groups by capitation originated with Kaiser Permanente and several other regional group and staff model health maintenance organizations (HMOs), such as Group Health Cooperative of Puget Sound. In the decades after World War II, Kaiser Permanente’s HMO product gained a significant foothold in most California urban areas.

In the 1970s, the federal HMO Act (which Congress let expire in the mid 1980s) and California’s Knox-Keene Act encouraged the proliferation of HMOs and widened their definition to encompass physician participation via IPAs paid by capitation. Perhaps because Californians were already familiar with Kaiser Permanente plans, the prepaid health plan model flourished once people could gain access to private practice physicians in an IPA-HMO plan.

Over time, physician groups in California grew large through consolidation, and many sought to profit by capturing a larger share of health care premium revenues from health plans. California law permitted physician groups to assume “global risk,” provided they themselves secured what amounted to HMO licenses. In effect, some physician groups became health plans within health plans.

The trend slowed in the mid-1990s, partly as a result of competition from newer “open access” health plans that touted more freedom of movement for patients at a time when the economy was vibrant and health care cost growth seemed to have abated. Another reason for the slowdown, however, was that a number of physician groups collapsed as a result of taking on more risk than they had the capacity to manage. These groups did not have the capital needed to absorb upswings in health costs, and they also lacked essential tools to monitor and control consumption of health services in a timely manner.

What concerns did the expansion of capitation engender among California policymakers and consumer advocates, and what regulatory remedies were put in place to address them? Oversight to assure that providers are delivering appropriate care takes different forms, depending on how payments are structured. When health care providers are paid a fixed amount regardless of how much care is delivered, an important area for regulatory oversight is ensuring that the amount of care is sufficient. In contrast, when providers are paid on a fee-for-service basis, oversight is needed to prevent providers from delivering care that patients don’t need. California addressed concerns about the quality of care provided under capitation by establishing both rules and agencies to guard against inadequate levels of care and to ensure appropriate levels of risk-sharing between parties.

The State of California set up multiple levels of appeal. A patient or physician who believes necessary care is being denied may first appeal to the physician group, which conducts an internal review. If the internal review upholds the decision, the patient can then appeal to the health plan. If the decision is upheld there, the patient can appeal to the California Independent Medical Review (IMR) board, a panel made up of independent medical professionals and managed by a state agency.¹ According to one source, approximately 75 percent of appeals to the IMR are upheld, which suggests that while physician groups are largely providing the necessary care, there remains a need for regulatory oversight to ensure services are not improperly denied.²

Another concern is the financial solvency of physician groups and their ability to manage risk. Reacting to the dislocations from the physician group failures of the 1990s, the California legislature acted to ensure that any organization responsible for paying for patient care is financially able to meet its obligations so that patients do not lose access to care. In 2005, the legislature passed S.B. 260, requiring any risk-bearing organization (RBO)

to collect and report specific organizational and financial information to the Department of Managed Health Care (DMHC). If a provider group lacks sufficient resources to continue accepting risk, the state prohibits the group from accepting capitation contracts.

Many experts in the California health care community believe these rules have led to greater stability in capitation contracts over the past few years. The RBO requirements ensure that physician organizations do not take on more risk than they can handle, and that a group always has enough cash available to pay physicians for patient care.

Looking beyond provider solvency, California has sought to ensure that health plans offer good access to services. The Department of Managed Health Care imposes regulatory requirements on HMOs regarding provider accessibility and the adequacy of provider networks. California HMOs are subject to specific physician-enrollee ratios and distance standards for the location of providers, and must receive prior regulatory approval of provider networks.

Has capitation influenced health care practice in California (e.g. use of e-mail, electronic records, etc.)?

A number of market forces have caused physicians in California to consolidate their operations to a greater degree than elsewhere in the nation. Consolidation promotes economies of scale that support investments in health information technology (HIT) as well as the application of evidence-based medicine standards. The physician group establishes practice guidelines, helps physicians install and run HIT systems, and purchases medical technology and other needed capital equipment that can be used by physicians throughout the entire organization. These aids are difficult for small group or solo providers to acquire independently, yet such advanced tools are needed for controlling health care costs while improving quality.

Practice consolidation has allowed physicians in California to invest in information technology at higher rates than in other parts of the U.S. For example, according to a CHCF study, 37 percent of physicians in California report using electronic health records (EHRs), compared to 28 percent nationally. As might be expected, larger practices of ten or more physicians are more likely to use EHRs than solo practitioners (13 percent).³

Medical group size, capitation, and adoption of HIT tend to be linked. Only relatively large medical groups are well-positioned to accept capitation payments. The financial stability that sometimes accompanies size has helped some large medical groups to be early HIT adopters. Yet not all large medical groups in California rely primarily on capitated payments, nor are they all on the vanguard of HIT adoption.

With respect to cost, service use, and quality, what do we know about the impact of capitation in California?

Why don't we know more? A California HealthCare Foundation-funded analysis shows that hospital use near the end of life is lower among HMO enrollees than patients covered by plans that pay providers under fee-for-service.⁴ With the exception of that focused analysis, however, data on cost, use and quality of care in capitated physician groups are limited, making it difficult to compare the results under capitation with other payment arrangements.

Historically, health plans and employers did not demand detailed information from physician groups. Knowing that a defined package of services would be delivered for a preset price was sufficient. Moreover, cost trends for capitated groups were favorable and quality concerns were not evident. The groups themselves had little incentive to be transparent; doing so both added administrative expense and gave customers a window into the groups' proprietary financial data.

Physician groups hesitate to divulge underlying utilization and cost patterns, in part because sharing such information might help health plans negotiate lower capitation rates. However, health plans and employer groups continue to look for ways to examine the information on processes and outcomes, in an effort to better understand the full return on their health care investment.

Greater transparency with respect to utilization would allow physician groups to assuage concerns about care levels and quality. The uncertain influence of market power among payers, health plans, and providers in determining the outcome of financial negotiations makes the impact of cost transparency less clear.

Implications for Federal Policy

In designing payment reforms, what lessons does California's experience with capitation and delegation of risk have to offer federal policymakers? California's broad-based use of capitation demonstrates that this form of payment could be employed on a large scale. The delegated model embodies the incentives that policymakers are seeking as they strive to promote affordability and quality of care.

However, successful use of capitation hinges on certain conditions. The lessons from California suggest the need for formal organizational arrangements among participating physicians with rewards for providing appropriate care and possible penalties for failing to reach quality standards, plus regulations and external oversight to protect physician solvency and ensure proper patient care. Greater transparency about performance under capitation would also help payers and the public have more confidence in the relative value being delivered by delegated physician groups.

AUTHORS

Eric Hammelman, Narda Ipakchi, Jennifer Snow, and Bob Atlas of Avalere Health, LLC.

ABOUT THE FOUNDATION

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

ENDNOTES

1. California Department of Insurance. *Consumers: IMR Program*. Los Angeles, CA: July 2002 (revised), www.insurance.ca.gov/0100-consumers/0020-health-related/0020-imr/#whatisimr.
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