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California's Physician Practice Landscape:
A Rapidly Changing Market with Limited Data

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AUTHORS
Jill Yegian, PhD, and Marta Green

About the Authors

Jill Yegian, PhD, is principal at **Yegian Health Insights**, which provides strategic planning, market and policy analysis, and program design and implementation support aimed at improving the health care system on behalf of patients, providers, and payers. Marta Green is the founder of Marta Green Consulting and brings her more than 20-year public-sector health care executive leadership experience to projects designed to improve health care delivery, patient protection, and affordability.

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Introduction

The practice settings of the approximately 75,000 physicians in active practice in California[1] are many and varied, with a wide range of size, ownership, legal structure, and affiliations. Further, those practice settings are rapidly evolving in a changing market and policy environment. At the health system level, market consolidation has accelerated, raising concerns about market power, increasing prices, and the erosion of independent practices.[2] COVID-19 has exacerbated challenges faced by providers, particularly small independent practices, and accelerated physician retirement and exit.[3] The role of private equity has expanded in health care, including among physician practices, generating debate about the implications for costs and patient care.[4] Health care costs continue to increase,[5] crowding out other spending priorities and creating affordability and access challenges for patients.

Physician services account for 20% of total health care spending, the second largest category behind hospital care at 31%.[6] Despite physicians' central role in delivering care to California residents, information about the structure, characteristics, business practices, contractual arrangements, and financing of physician practices is piecemeal, siloed, and may not be publicly available. In addition, lack of shared definitions and language about the structure and characteristics of physician practices and organizations can create confusion, exacerbated by the tremendous variation and complexity in contractual relationships and payment arrangements, including delegated responsibilities between payers and providers.

The purpose of this paper is twofold. First, to review available information sources on the physician practice landscape in California with a focus on existing regulatory and reporting requirements. Second, to begin to create common language and terminology about physician practices and organizations with the goal of enabling a more substantive discussion of relevant policy issues — highlighting gaps in currently available information, and possibilities and prospects for a potential Office of Health Care Affordability, which may require additional reporting from many actors in the health care system.[7]

Physician Practice Landscape in California: Limited Information Available

There are many sources of information on aspects of California's physician services market, but no data source provides a complete picture — either nationally or specific to California. This section provides a broad outline of data sources, and describes general characteristics and trends based on those sources.

While some physicians practice solo, the majority affiliate with other physicians in some capacity. A primary driver of affiliation is access to resources that require scale. Examples include leverage in contracts with health plans, the financial resources required to accept risk for defined patient populations, administrative support for compliance with regulatory oversight, and the capabilities and tools to effectively manage populations, such as access to comprehensive electronic medical records (EMRs) and data analytics for population health, quality measurement and reporting, and utilization management. Another important consideration for practicing physicians is whether to practice independently or to enter an employment relationship.

Results from the Benchmark Study, a survey of physicians by the American Medical Association (AMA), provides a national snapshot and illustrates the many interrelated aspects of physician affiliation.[8]

- **Employment status.** In 2020, 50.2% of physicians were employees, 44.0% were owners, and 5.8% were independent contractors. Those numbers have shifted away from ownership and toward employment since 2012, when 41.8% of physicians were employees, 53.2% were owners, and 5% were independent contractors.

- **Type of practice.** In 2020, 14.0% of physicians were in solo practice, 42.6% in single specialty groups, 26.2% in multispecialty groups, 9.3% were hospital employees or contractors, 2.9% participated in a faculty practice plan, and 5.0% were in another type of practice, including ambulatory surgery center and urgent care facility.

- **Practice size.** In 2020, 33.6% of physicians practiced in a group of fewer than five physicians, 20.0% in a group of 5 to 10, 11.5% in a group of 11 to 24, 7.8% in a group of 25 to 49, and 17.2% in a group of 50 or more. Another 9.7% were direct hospital employees or contractors.[9]

Similar data are not regularly collected and made publicly available for California physicians. In 2015, University of California, San Francisco, researchers collaborated with the California Medical Board to survey California physicians, gathering information about primary practice location. Of those in active practice (defined as working at least 20 hours per week), 29% reported solo practice, 31% practice in groups of up to 49 physicians, 16% in groups of 50 or more, 12% with Kaiser, and 11% in other practice settings including community health centers (such as Federally Qualified Health Centers) and the Department of Veterans Affairs.[10] Information was not gathered on employment status or type of practice, and that survey has not been repeated.

Further complicating the landscape in California, physician practices may have many different relationships and affiliations, some of them nesting within others. Even if more complete data were available, mapping those layered relationships creates a challenge. Physicians map to practices; practices may map to medical groups and independent practice associations (IPAs); medical groups and IPAs may map to health systems or to payers or other entities. Many of these relationships are nonexclusive or one-to-many; for example, a physician practice may belong to multiple IPAs. Further, IPAs may be created or disbanded based on the opportunity for specific health plan contracts. Affiliation with IPAs may change regularly based on the status of health plan contracts, and as such, the IPA landscape is fluid. The Agency for Health Care Research and Quality (AHRQ) Comparative Health System Performance Initiative delves into the enormous complexity in defining and describing health systems.[11] The Compendium of U.S. Health Systems, updated January 2021, provides data on 637 health systems that include at least one hospital and at least one group of physicians. It includes a group practice file that identifies 39,103 physician group practices along with their health system affiliations.[12]

Research projects have generated some useful information about physician practice settings and characteristics with funding from philanthropic and government organizations such as the California Health Care Foundation, Robert Wood Johnson Foundation, and AHRQ. For example, the National Study of Physician Organizations, led by researchers at UC Berkeley between 2000 and 2012, generated descriptive information about California physician organizations and investigated capabilities such as care management processes.[13] More recently, the National Survey of Healthcare Organizations and Systems and the RAND Center of Excellence on Health System Performance have generated information about physician practice characteristics and performance.[14] Researchers sometimes rely on proprietary data sets developed to support marketing and other industry activities to provide a sampling frame or to support mapping of relationships among providers delivering care.[15] Health

services research efforts are valuable but episodic, and unless specifically designed (and funded) to do so, they do not provide California-specific results.

Many market observers are familiar with the Cattaneo & Stroud medical group reports, which provided relatively more detailed, publicly available information on California medical groups and IPAs for decades before completing the last full update in 2017 and a partial update in 2019.[16] The reports, which include groups with at least six primary care physicians and at least one contract with an HMO, are notable for their comprehensiveness and level of detail, though some information is aggregated (e.g., physician organization enrollment is not available by line of business) and usability is limited by the PDF format of the reports. The termination of the reports has left a gap in available data.

Relatedly, the Integrated Healthcare Association's California Regional Health Care Cost and Quality Atlas is a benchmarking tool that aggregates and reports data at the member level from commercial insurance, Medicare, and Medi-Cal related to clinical quality, total cost of care, and hospital utilization.[17] Atlas does not directly measure specific physician organizations; rather, it measures populations cared for by providers under different risk arrangements (e.g., no risk, partial risk, full risk). Reports have covered topics such as regional variation and the association between financial risk sharing and performance.

While each of these reports and research projects illuminates an aspect of the physician practice or organization landscape in California, a complete picture that is regularly updated and publicly available is lacking.

Medical Groups and Independent Practice Associations

In medical groups, often called group practices, physicians are typically employees or shareholders. Physicians are generally paid by salary, often with performance incentives. Medical group resources are shared and centralized, including office space, personnel, and tools such as electronic medical records. Billings and revenues are managed by the group rather than by individual physician practices. As a result, medical groups are generally considered to be both clinically and financially integrated.

IPAs, by contrast, are virtual networks of contracted practices; each practice remains independent and may belong to multiple IPAs. IPAs often provide access to a common EMR or to other shared services such as data analytics. However, the value of centralized services can be diminished by the nonexclusive nature of many physician-IPA relationships.

Several industry groups manage annual data collection and reporting efforts focused on medical groups and IPAs, but information on organization characteristics and relationships are not publicly available. The Integrated Healthcare Association (IHA) annually awards "Excellence in Healthcare" to the top-performing physician organizations based on clinical quality, patient experience, and cost.[18] America's Physician Groups (APG) conducts an annual survey of members designed to evaluate coordinated care infrastructure and value-based performance; it awards "elite" status to a subset.[19] California's Office of the Patient Advocate publishes an annual Medical Group Report Card that relies on data from IHA and from the Purchaser Business Group on Health's annual Patient Assessment Survey to support an interactive tool that allows the user to assess the performance of physician organizations by county based on quality and patient experience. A Directory of Medical Groups provides descriptive information on physician organizations, but the source and date of the most recent update are not clear.[20]

Ownership of Physician Entities

Nationally, based on the AMA Benchmark Study results, 49.1% of physicians were in practices wholly owned by physicians in 2020 — down from 60.1% in 2012. The share of physicians in practices owned at least in part by hospitals increased from 23.4% in 2012 to 30.5% in 2020, while direct hospital employee/contractor relationships rose from 5.6% to 9.3%. Private equity appeared for the first time, accounting for 4.4% of physicians.[21]

In California, as in the US, an increasing share of physician practices are owned by hospitals and health systems. A 2019 study showed that the share of primary care physicians in practices owned by hospitals and health systems increased from 24% to 42% between 2010 and 2018; an even greater increase was observed among specialists, from 25% to 52%.[22] An analysis of California health systems using AHRQ's Comparative Health System Performance database found increasing concentration in the largest health systems, as shown in Table 1. In 2018, the 10 largest systems accounted for 46.0% of all physicians in California, up from 30.7% just two years earlier.

As physician concentration in large systems increases, questions have arisen about the apparent inconsistency between growing corporate control of physician practices and California's ban on the corporate practice of medicine. The corporate practice ban has been in place since 1928, with the intention of protecting patients by ensuring that clinical decisionmaking remains with physicians rather than with corporate entities. In recent years, there is an increasing tension between those who view the ban on corporate practice as an obstacle to integrated delivery of care and those who view it as the last bulwark against the consolidation of the delivery system and the erosion of independent practice. Regardless of perspective, many believe that as a practical matter, the ban on the corporate practice of medicine is largely toothless. A 2007 report by

Table 1. Number of Physicians in the 10 Largest Health Systems in California, 2016 and 2018

	2016	2018
Kaiser Permanente	15,586	18,241
University of California Health	5,198	10,145
Dignity Health	1,730	7,821
Sutter Health	3,250	6,215
Providence St. Joseph Health	956	4,435
Stanford Health Care	2,452	3,081
Los Angeles County Health Services Department	1,652	1,983
Cedars-Sinai Health System	968	1,841
Sharp HealthCare	596	1,623
Adventist Health	724	1,420
Total, 10 largest systems	**33,112**	**56,805**
All largest systems percentage of statewide total	**30.7%**	**46.0%**

Note: Approximately 5% of physicians are counted as members of more than one system.

Source: ***An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California*** (PDF), State of California, August 2020, 55 (from AHRQ/Mathematica analysis of data from the AHRQ Comparative Health System Performance database).

the California Research Bureau, produced at the request of the Assembly Committee on Health, noted that "corporate managed care organizations now dominate the health care environment, and even physicians who are not employed by them are likely to contract to provide services for them. Health care service providers have also integrated both vertically and horizontally, and increasingly contract with management service organizations, which perform administrative and oversight functions to increase the efficiency of practices. These changes have effectively circumvented the CPM doctrine."[23]

A 2016 report from the California Research Bureau reviews several exemptions from the ban on the corporate practice of medicine created in statute or through legal decisions. Among the entities legally allowed to employ physicians are medical schools and teaching hospitals, community health centers, county hospitals, and state agencies such as the California Department of Corrections and Rehabilitation. In addition to the exemptions, strategies have emerged that allow hospitals and other non-physician-owned entities to affiliate with physician organizations without violating the corporate ban.[24] Generally, these strategies feature a common theme: The corporate entity (such as a hospital or management services organization) enters into a professional services agreement with the physician organization, creating a contractual rather than an ownership relationship. A brief overview of some of the main types of physician practice ownership is provided below.

Medical foundations. Medical foundations, sometimes called 1206(l) foundations in reference to the California Health and Safety Code section that defines them, are often used by hospitals to affiliate with physician organizations in compliance with the ban on the corporate practice of medicine.[25] Medical foundations must have a nonprofit 501(c)3 structure and meet several specific criteria, including conducting medical research and health education and providing patient care through a group of at least 40 physicians, at least 10 of whom are board-certified and at least two-thirds of whom practice full-time through the foundation. The medical foundation typically holds the contracts with health plans, owns the tangible assets of the physician organization, and employs the nonphysician personnel; the foundation contracts with the physician practices through a professional services agreement. Examples of medical foundations include Cedars-Sinai Medical Care Foundation (affiliated with Cedars-Sinai Medical Center), Dignity Health Medical Foundation (affiliated with CommonSpirit Health), Sutter Bay Medical Foundation (affiliated with Sutter Health), and University Health Care Alliance (affiliated with Stanford Health Care). In some cases, a health system may have multiple affiliated medical foundations. For example, Providence Health System is affiliated with Facey Medical Foundation, Providence St. John's Medical Foundation, and St. Joseph Heritage Healthcare.[26]

Payer ownership. Health insurance companies including Centene, Cigna, Humana, and Anthem, have purchased or invested or both in physician entities across the country.[27] OptumHealth, owned by United Healthcare, has become a major player. In Southern California in recent years, Optum purchased multiple physician entities – including two of the largest in the state, Monarch and DaVita Healthcare Partners.[28] According to a recent post in *Health Affairs Blog*, "With over 50,000 physicians owned or in affiliated independent practice associations (IPAs), United may today be the largest employer of physicians in America, and it plans to add 10,000 more physicians in 2021."[29] In 2020, Altais, a Blue Shield of California company, purchased Brown & Toland Physicians, a 2,700-physician IPA in Northern California.[30]

Investor ownership. Companies focused on physician services have grown, gone public, and

engaged in mergers and acquisitions at a rapid clip in recent years. Among the many examples are One Medical and Vera Whole Health. One Medical, a membership-based primary care company with a presence in the Bay Area and Southern California, went public in 2020 and acquired Iora Health, a primary care company focused on team-based care, for $2.1 billion in 2021.[31] Vera Whole Health, a multistate company focused on employer-sponsored advanced primary care, with California sites in Oakland and Santa Rosa, is majority-owned by investment firm Clayton, Dubilier & Rice and recently received $50 million in investment from Morgan Health.[32]

Private equity ownership. Private equity companies are taking an increasing ownership stake of physician practices. Hospital outsourcing of anesthesiology and emergency services has created an opportunity for private equity firms to purchase physician practices and "roll them up" into physician staffing firms that employ thousands of physicians.[33] Examples include Envision Healthcare, owned by Kohlberg Kravis Roberts & Co., and TeamHealth, owned by Blackstone. Nationally, the specialties most likely to be targeted for acquisition by private equity firms between 2013 and 2016 were in anesthesiology (19% of groups and 33% of physicians acquired by private equity firms were in anesthesiology), multispecialty (19% of groups, share of physicians varies by specialty), emergency medicine (12% of groups, 16% of physicians), family practice (11% of groups, 9% of physicians), and dermatology (10% of groups, 6% of physicians).[34] According to an analysis of the private equity landscape in physician practice, the firms "describe their role as a management services organization (MSO) that has bought up all the financial assets of the physician practice, but has placed leadership of medical practice in the hands of a chief medical officer who is a physician and a partner in the practice. The document governing the relationship between the MSO and the physician group typically provides that the management services organization can fire and replace the chief medical officer, giving the MSO de facto influence over requirements for revenue generating and cost saving goals for individual doctors."[35] There is an active debate over the implications of the growing role of private equity in physician practice,[36] and a resistance movement has emerged among emergency physicians.[37]

The changes in the physician practice market have recently garnered attention from the Federal Trade Commission (FTC). In April 2021, the FTC announced a study to evaluate the potential anticompetitive effects of physician mergers, consolidation, and shifts in ownership. Noting the "dramatic restructuring" in US physician markets and the paucity of research on the effects of mergers and acquisitions of physician practices on competition, the study will examine the effects on provider prices, competition, and patient outcomes. The 15-state study, which does not include California, will rely on claims data submitted to the FTC from six national health insurance companies.[38]

Capitation and Delegation Among California Physician Organizations

Many physician organizations of varying size in California accept financial risk in the form of capitation, receiving a fixed amount per member per month to provide medical care to a defined patient population. California's medical groups and IPAs have long been recognized for a distinctive role in the market that places them at the "core of the delivery system"[39] and as key drivers of the "unique brand of managed care in California."[40] As discussed below, in certain circumstances, capitation and delegation lead to enhanced reporting by physician organizations. As a result, much more is known about many of these physician organizations in California.

Acceptance of financial risk in the form of capitation often requires that physician organizations build or outsource capabilities such as claims payment, data analytics, and actuarial and financial modeling.

Health plans and physician organizations use a framework called the "division of financial responsibility" (DOFR) to allocate financial responsibility for services. DOFRs provide the key to understanding the level of risk delegation between the plan and physician organization. Often, the physician organization is responsible for professional services (primary and specialty care, and ancillary services such as diagnostic imaging and laboratory tests) while the health plan retains responsibility for institutional risk (facility-based services such as inpatient care). Alternatively, the physician organization may accept global risk (for both professional and institutional services). Capitated physician organizations often enter into contracts with additional providers, often called "downstream" providers, to ensure their ability to provide the services agreed upon in the DOFR. For example, a multispecialty medical group may contract with a practice of specialists not represented within the group. There is wide variation in the interpretation of DOFRs, which are not standardized across health plans. An industry effort has been ongoing for years to transition to a "coded DOFR" that relies on specific medical and procedure codes rather than broad service categories.[41] Adoption of a uniform DOFR template across health plans and physician organizations in California would increase understanding of the allocation of risk, enabling researchers and policymakers to assess market trends over time through longitudinal study of changes in DOFRs.

Along with capitation, in California, health plans often delegate responsibility to physician organizations for functions such as provider credentialing, utilization management, care coordination, network management, and quality reporting.[42] The California Department of Managed Health Care holds health plans responsible for these functions and requires that health plans oversee any entities delegated to carry them out.

Table 2 provides summary information from Cattaneo & Stroud's *Active California Medical Group Market* report, last updated in 2019. The 324 physician organizations with at least six primary care physicians and one HMO contract collectively accounted for an estimated enrollment of 21.1 million Californians[43] — over half of California's 2020 total population of 39.5 million.[44] The majority of the groups were IPAs and foundations or community clinics (80%), but they accounted for less than half of enrollment. Kaiser, with over nine million members in 2021,[45] accounted for a large share of the group practice enrollment.

Table 2. Enrollment in Physician Organizations, by Group Type, 2019

	NUMBER	PERCENTAGE	ESTIMATED ENROLLMENT
Group Practices, including Kaiser	42	13%	10,553,977
Independent Practice Associations	139	43%	5,710,966
Foundations / Community Clinics	121	37%	3,304,329
University of California and County Groups	22	7%	1,549,190
Total	**324**	**100%**	**21,118,462**

Source: ***The Active California Medical Group Market*** (PDF) (as of March 15, 2019), Cattaneo & Stroud.

The largest physician organizations, by enrollment range, were:

- 600,000+ enrollees (4): Southern California Permanente Medical Group, Permanente Medical Group (Northern California), Heritage Provider Network, and HealthCare Partners Associates Medical Group (now Optum)
- 500,000 to 599,999 (1): Health Care LA IPA
- 400,000 to 499,999 (2): Employee Health Systems Medical Group (now defunct) and Los Angeles County Department of Health Services
- 300,000 to 399,999 (2): Vantage Medical Group, Allied Pacific IPA / Allied Physicians IPA

Many physician organizations rely on an MSO for administrative services including network management (provider credentialing, claims), financial management (actuarial, financial reporting), provider services (contracting, provider relations), and population health (predictive modeling, utilization management). Many MSOs are "captive," meaning they are dedicated to a single physician organization (or other entity); in other cases, MSOs serve many clients. MSOs are not physician organizations and are restricted to nonclinical services due to California's ban on corporate practice of medicine, but they have been playing an increasingly significant role in the market. According to America's Physician Groups, MSOs enable participation in Medi-Cal managed care of small physician organizations that do not have sufficient patient enrollment to support robust infrastructure and would otherwise lack the capacity to meet program requirements.[46]

There may be multiple layers of capitation and delegation. For example, a physician organization capitated and delegated by a health plan may pass on (subcapitate) financial risk for a defined population and specific set of services to another physician organization (perhaps a specialty group such as cardiology) while contracting with an MSO for administrative support. There is enormous variation and complexity in contracting arrangements at all levels.

Physician Practice: Reporting Requirements and Available Data

Health services research and industry efforts to collect data and report on the physician practice landscape have produced valuable information, but these voluntary efforts depend on willingness to participate and availability of resources. When reporting is mandatory, as is the case for risk-bearing organizations, more complete and regular data become available.

The California Department of Managed Health Care (DMHC) was created in 1999 by SB 260, which shifted responsibility for enforcement of the Knox-Keene Act from the Department of Corporations. SB 260 also defined risk-bearing organizations (RBOs), exempted them from Knox-Keene Act licensure, established RBO registration and reporting requirements, and created the Financial Solvency Standards Board (FSSB).[47] Together with Knox-Keene licensure of health care service plans and 2019 regulations that defined global risk and clarified associated requirements, SB 260 makes DMHC the primary source of information on physician organizations in California. Yet not all physician practices and organizations that bear financial risk meet the definition of an RBO. To increase understanding of the landscape, a useful typology can be developed anchored on degree of risk-bearing and on inclusion and exclusion from DMHC reporting requirements. Table 3 presents a summary of three types of physician organizations: restricted licensees (global risk), risk-bearing organizations, and other types of physician practices (see page 11).

Table 3. Comparative Summary of Physician Organizations

	RESTRICTED LICENSEE (GLOBAL RISK)	RISK-BEARING ORGANIZATION	OTHER TYPES OF PRACTICES
Description	Accepts professional and institutional risk	Accepts professional risk, pays downstream claims, and is owned by physicians	Includes "RBO Look-Alikes," (see text for details), practices that accept capitation but do not pay downstream claims, and those that do not accept financial risk
License required	Must obtain restricted Knox-Keene license from DMHC.	No, but registration and financial reporting to DMHC are required.	No
Reporting requirements	**Commercial and Medi-Cal.** Periodic reporting is required on financial, claims payment, geographic and timely access, grievance, and appeals. Audited every three years. **Medicare only.** Reporting and auditing is limited to financial and claims payment (federal law preempts regulation of anything other than financial stability).	Quarterly and annual financial solvency reporting required (monthly if the RBO is on corrective action plan or "closely monitored" list). Detailed financial solvency reports and corrective action plans are not public.	None
Financials	Monitored and audited by DMHC, restricted licensee financials are available at plan level but not at physician organization level.	Monitored by DMHC, info is released in aggregate but not at physician organization level.	No information
Solvency	Monitored by DMHC, audited every three years or as needed if problems arise.	RBO quarterly reporting updates, including updates on corrective action plans, are provided at the Financial Solvency Standards Board public meetings.	No monitoring
Number	24 (in 2020, see Table 6)	201 (in 2020, see Table 4)	Not known
Enrollment	2.2M total (in 2020): 960K commercial, 540K Medi-Cal, 700K Medicare (see Table 6)	8.8M total (as of 9/30/2021): 2.7M commercial, 4.9M Medi-Cal, 1.2M Medicare	Not known

Source: Author analysis of **laws and regulations** regarding California Dept. of Managed Health Care (DMHC) requirements for risk-bearing organizations and health plans; custom data request, DMHC; author analysis of RBOs' "**Statement of Organization**" (2020), DMHC; and ***Provider Solvency Quarterly Update***, DMHC, February 23, 2022.

Risk-Bearing Organizations

Risk-bearing organizations are required to register with DMHC and to report financial information quarterly and annually. RBOs generally self-identify to DMHC as meeting the RBO definition. In some cases, health plans may require that physician organizations that contract for capitated and delegated services obtain a determination from DMHC regarding RBO status. DMHC's role in financial monitoring of RBOs can be helpful to health plans, given that the plans are ultimately responsible for oversight of their contracted RBOs.

The plain-language version of the RBO definition is an organization that is wholly owned or organized by physicians and does all the following: (1) contracts with a health plan or arranges for health care services for the health plan's enrollees, (2) receives compensation for those services on a capitated basis, and (3) pays "downstream" providers for services covered under the capitation payment (based on claims submitted, subcapitation, or other payment arrangements). RBOs are required to submit financial information quarterly that includes a balance sheet, an income statement, a statement of cash flows, a statement of net worth, cash and cash equivalent, receivables and payables, risk pool and other incentives, claims aging, notes to financial statements, enrollment information, mergers and acquisitions and discontinued operations, the incurred but not reported methodology, and administrative expenses. Annual reporting requires the same set of information based on the organization's audited financial statement prepared by an independent certified public accountant in accordance with generally accepted accounting principles.

Definition of a Risk-Bearing Organization

California's Department of Managed Health Care defines a risk-bearing organization as follows:

A risk-bearing organization (RBO) is either a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206 of the Health and Safety Code, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services. An RBO does not include an individual or a health care service plan. An RBO does all of the following:

- Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees.
- Receives compensation for those services on any capitated or fixed periodic payment basis.
- Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan when those services are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization.

Source: "**Risk Bearing Organization (RBO) Frequently Asked Questions**," California Dept. of Managed Health Care.

A major update to the regulations governing RBOs was released by the DMHC in 2019, resulting in several changes to reporting and an increase in the financial solvency requirements.[48] All RBOs are now required to submit financial reports. Previously, those with fewer than 10,000 lives needed to file only a compliance statement attesting to meeting DMHC's requirements but were not required to submit financials. In addition, subdelegated RBOs are now required to report financials. Previously, only those RBOs contracting with a health plan were required to report. As of October 1, 2021, the filing forms also require the disclosure of "sponsoring organizations" and the contributions from those entities. DMHC now limits the term of that sponsorship such that the RBO must demonstrate its ability to stand on its own financially.

In 2020, 201 physician organizations were registered as RBOs with DMHC. Table 4 shows the distribution of RBOs by number of lives and ownership model. Forty percent of RBOs had fewer than 5,000 lives, and another 23% had between 5,000 and 19,999 lives. The vast majority of RBOs — over 80% — were independent practice associations; about 7% were medical foundations and 6% were medical groups. In 2020, one RBO (with 5,000 to 19,999 lives) reported that all enrollment flows through another RBO; that is, the RBO holds no health plan contracts. The summary data make clear that a large share of RBOs — by definition, physician organizations accepting financial risk for professional services and paying downstream claims — are very small IPAs that likely rely on external support from MSOs for administrative and related services. The current profile of RBOs, together with the history of bankruptcies in the 1990s that led to the passage of SB 260 and the creation of the FSSB, highlight the importance of DMHC's financial solvency monitoring role.

While illuminating, the RBO data are incomplete for the purpose of characterizing physician organizations that contract with health plans on a capitated and delegated basis. Statute or DMHC determination excludes some physician organizations, including Kaiser Permanente Medical Groups and University of California–affiliated groups (see "RBO Look-Alikes" elsewhere in this report for details).[49] Other physician organizations report financials under an affiliated entity such as another RBO or a health care service plan. DMHC tracks these reporting

Table 4. Risk-Bearing Organizations, by Number of Lives and Ownership Model, 2020

NUMBER OF LIVES	FOUNDATION	IPA	MEDICAL GROUP	OTHER/MISSING*	TOTAL
0–4,999	0	74	3	4	**81**
5,000–19,999	1	42	3	0	**46**
20,000–49,999	5	26	4	1	**36**
50,000–99,999	2	8	2	0	**12**
100,000–199,999	4	10	0	0	**14**
200,000+	2	7	0	3	**12**
Total	**14**	**167**	**12**	**8**	**201**

* Includes two RBOs self-reporting as both medical group and independent practice association.

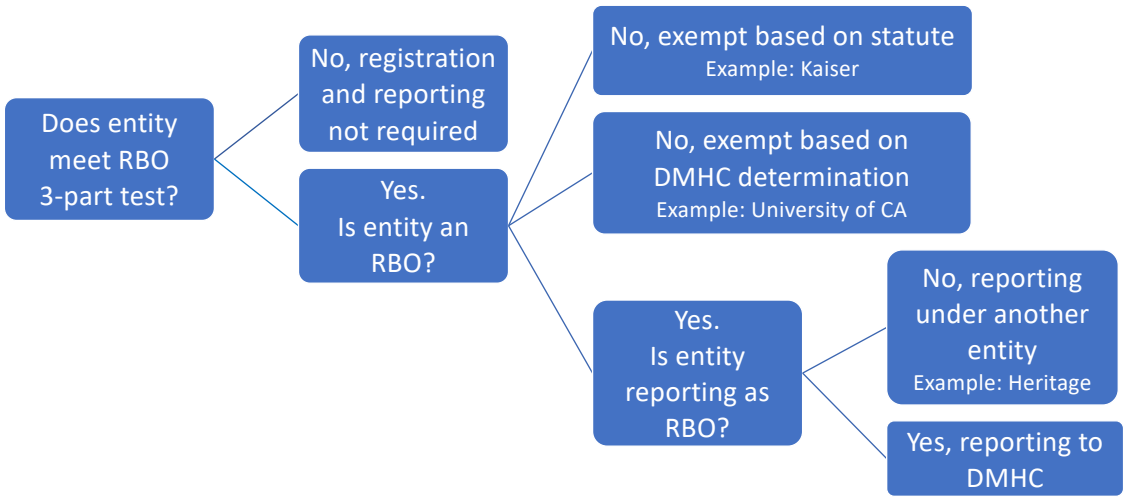
Source: Author analysis of RBOs' "**Statement of Organization**" (2020), California Dept. of Managed Health Care.

relationships and can carry out its monitoring activities related to financial solvency and consumer protection, but those interested in using RBO data to understand California's market lack information about which RBOs are reporting through affiliated entities. Exhibit 1 represents a schematic describing RBO classification and reporting.

RBOs that meet the three-part test but are not included in the RBO data may be reporting through a related entity. If a physician organization's financial reporting is included in the consolidated financial statements filed with DMHC by a health plan or affiliated RBO, then the physician organization may not need to file separately. Examples include:

- Heritage Provider Network, operating in Southern California, has a limited Knox-Keene license (one of only two licensees, held over from when DMHC shifted to "restricted" licenses) and reports financial information to DMHC on behalf of multiple physician organizations: ADOC Acquisition Co., A Medical Group; Bakersfield Family Medical Group; Coastal Communities Physician Network; Desert Medical Group / Oasis Independent Medical Associates; High Desert Medical, A Medical Group; Lakeside Medical Organization, A Medical Group; Regal Medical Group; Sierra Medical Group; and VVIPA Medical Group.
- Cedars-Sinai Health System has both a medical group, Cedars-Sinai Medical Care Foundation, and an IPA, Cedars-Sinai Health Associates. The IPA reports through the medical group, which is an RBO.
- Brown & Toland Physicians (also known as California Pacific Medical Group) and Hill Physicians Medical Group, two large Northern California IPAs, each has a restricted license for Medicare Advantage–only plans. Both entities report their global risk Medicare financial information as restricted licensees, while their professional risk-only contracts are reported through RBO filings.

Exhibit 1. Overview of RBO Classification and Reporting



Notes: *RBO* is risk-bearing organization; *DMHC* is California Department of Managed Health Care.
Source: Jill Yegian and Marta Green.

If a RBO reports only through its affiliated restricted licensee, only aggregate information is available (i.e., on the plan as a whole, not on each RBO). However, more detailed financial data are collected and publicly disclosed about health plans compared with RBOs. From RBOs, DMHC annually collects net worth, debt, and revenue and expenses, and uses the information to calculate tangible net equity, working capital, cash-to-claims ratio, and other indicators of financial health. Pursuant to current regulatory requirement, most of this information is not publicly available; DMHC publishes only whether the RBO's financial status meets regulatory guidelines.[50]

In contrast, DMHC collects similar financial data from health plans and makes them publicly available. Moreover, the financial data are available at much greater granularity for health plans (including restricted licensees) than for RBOs. For example, health plans break down their income by how much is collected in premiums, copayments, capitation, interest on investments, from government payers, and other categories. Expenses are broken out into inpatient, outpatient (primary care separate from other medical care), emergency room and pharmacy, and by capitated and noncapitated payments. Health plans also report on specific administrative expenses by category, including employee compensation, interest expenses, property expenses, marketing, and other costs. The degree of transparency regarding health plan financials on the DMHC website is in marked contrast to the information available about RBOs, and virtually no information is available on physician organizations not classified as RBOs.

Overview of Risk-Bearing Organizations

Of the 201 RBOs that reported to the DMHC in 2020, only 19 (9%) reported ownership by a hospital or health care system. Of the 12 largest RBOs, 3 reported such ownership: Dignity Health Medical Foundation, Rady Children's Specialists, and St. Joseph Heritage. A large majority (155 of 201) of RBOs reported using an MSO.

Collectively, RBOs had 8.8 million enrolled lives as of September 2021: 2.7 million in the commercial market, 4.9 million in Medi-Cal, and 1.2 million in Medicare.[51] The DMHC's Financial Solvency Standards Board meets quarterly, and the department provides a Provider Solvency Quarterly Update at each meeting. In February 2022, DMHC reported a total of 209 RBOs based on September 2021 data, with 12 (6%) on a corrective action plan (CAP).

Table 5 describes the 12 largest RBOs — those with 200,000 or more lives — based on the 2020 DMHC data (see page 16). They are concentrated in Southern California, with only two in Northern California and four others operating in both regions. Two of the 12 are structured as medical foundations, while 7 are IPAs; Optum combines the medical group and IPA structures. Given that the size categories are capped at 200,000 lives, some of these RBOs may have much larger enrollments. The number of physicians employed or under contract varies widely. Excluding Rady Children's Specialists and March Vision Care Group (restricted to pediatric and vision specialists, respectively), RBOs report primary care physician (PCP) numbers ranging from 140 for River City Medical Group to 2,171 for Optum, and specialists from 675 for Inland Faculty Medical Group to 8,570 for Optum. Variation may be due to enrollment size (some RBOs are likely close to the 200,000 cutoff while others are much larger). Degree of specialization and market segment play a role as well. Because physicians may belong to multiple IPAs, these numbers cannot simply be aggregated to create total physician counts.

Table 5. Risk-Bearing Organizations with More Than 200,000 Lives, California, 2020

RBO NAME, BY REGION	STRUCTURE	MANAGEMENT SERVICES ORGANIZATION	OWNED BY HOSPITAL OR HEALTH CARE SYSTEM?	PRIMARY CARE PHYSICIANS	SPECIALISTS
Southern California (6)					
Allied Physicians of California	IPA	Network Medical Management	No	592	726
HealthCare Partners (Optum)	IPA and Medical Group	OptumCare Management	No	2,171	8,570
Inland Faculty Medical Group	IPA	North American Medical Management	No	268	675
Preferred IPA of California	IPA	—	No	534	871
Prospect Medical Group	IPA	Prospect Medical Systems	No	1,580	5,011
Rady Children's Specialists of San Diego	Other	—	Yes (Rady Children's Hospital)	0	250
Northern California (2)					
Hill Physicians Medical Group	IPA	PriMed Management Consulting Services	No	1,520	3,485
River City Medical Group	IPA	Advanced Medical Management	No	140	1,500
Multiregional (4)					
Dignity Health Medical Foundation	Foundation	—	Yes (CommonSpirit Health)	258	723
LaSalle Medical Associates	IPA	Network Medical Management	No	575	1,841
March Vision Care Group	Other	March Vision Care	No	0	1,403
St. Joseph Heritage Healthcare	Foundation	—	Yes (Providence St. Joseph)	530	1,496

Source: Author analysis of RBOs' "**Statement of Organization**" (2020), California Dept. of Managed Health Care.

The DMHC does not release information on RBO enrollment by market segment (commercial, Medicare Advantage, and Medi-Cal), but a list of contracted health plans is available for each RBO. Ten of the 12 RBOs in Table 5 reported contracts with Medi-Cal managed care plans to the DMHC, and the other two may contract for Medi-Cal through health plans that serve both commercial and Medi-Cal (e.g., Anthem Blue Cross, Health Net). All of these RBOs were financially compliant as of September 30, 2021.[52]

Restricted Licensees (Global Risk)

The 2019 DMHC General Licensure regulations codified a long-standing interpretation of the Knox-Keene Act that an entity accepting both professional risk and institutional risk is required to be licensed as a health plan.[53] DMHC uses the category "restricted" license for entities that accept global risk from a health plan to indicate that the license is restricted to functions delegated by the health plan to the entity. Restricted licensees may not sell coverage directly to consumers; they must operate through a partner health plan that is fully licensed. More detailed information is publicly available on restricted licensees compared with RBOs because the same financial, operational, and consumer protection reporting requirements apply to both restricted and fully licensed plans. However, the information is aggregated at the plan level; restricted licensees reporting on behalf of multiple RBOs report a single set of financials (e.g., Heritage Provider Network reports on all its underlying physician organizations). As a result, when reporting shifts from the RBO level to the restricted licensee level, information is no longer available on each physician organization, but more detailed financial information is available. Further, every three years, DMHC performs on-site medical surveys looking at the organization's adherence to nonfinancial Knox-Keene requirements and on-site financial examinations into the organization's solvency, claims settlement, and other related financial indicators. Two legacy "limited" licenses exist from the period before DMHC's existence; the reporting requirements for these entities are identical to those of the restricted licensees.

As of September 2021, 24 health plans held a restricted or limited license from DMHC and had enrollment through at least one plan-to-plan contract. Of those, 8 were specific to Medicare Advantage, 1 was a specialized vision plan (for the Medicare Advantage market), and 4 plans — MemorialCare, Monarch, Prospect, and Heritage Provider Network — were active in all three market segments. A complete list of restricted Knox-Keene licensees and their enrollment, by market, is in Table 6 (see page 18).

Table 6. Restricted Knox-Keene Licensees and Enrollment, by Line of Business, California, as of September 30, 2021

HEALTH PLAN	RESTRICTED COMMERCIAL	RESTRICTED MEDI-CAL	RESTRICTED MEDICARE	TOTAL LIVES THROUGH PLAN-TO-PLAN CONTRACTS
Adventist Health Plan		18,454		18,454
AltaMed Health Network		82,433		82,433
AmericasHealth Plan	80		2,160	2,240
Bay Area Accountable Care Network (Canopy Health)	42,203		6,777	48,980
Dignity Health Provider Resources	20,284		11,125	31,409
EPIC Health Plan	34,131		32,840	66,971
MemorialCare Select Health Plan	2,789	56,333	235	59,357
Monarch Health Plan	35,315	94,869	40,503	170,687
Optum Health Plan of California (formerly DaVita)	296,767		151,717	448,484
PIH Health Care Solutions			16,608	16,608
Premier Eye Care			70,353	70,353
Premier Health Plan Services			5,019	5,019
Prospect Health Plan	2,717	40,247	18,782	61,746
Providence Health Network	97,872		20,929	118,801
Medicare Advantage–Only Health Plans				
Access Senior HealthCare			2,005	2,005
Brown & Toland Health Services			21,626	21,626
Choice Physicians Network			13,310	13,310
For Your Benefit			4,402	4,402
Hill Physicians Care Solutions			2,305	2,305
Imperial Health Plan of California			10,849	10,849
Medcore HP			10,702	10,702
Meritage Health Plan			4,173	4,173
Limited Health Plans				
Heritage Provider Network	272,512	245,994	172,538	691,044
PRIMECARE Medical Network	155,128		74,617	229,745
Total Enrollment	**959,798**	**538,330**	**693,575**	**2,191,703**
Number of Plans	**11**	**6**	**22**	**24**

Source: Custom data request, California Dept. of Managed Health Care.

Other Types of Physician Practices and Organizations

Outside the relatively narrow realm of RBO and restricted licensee data, much less is known about the number, size, structure, contracting arrangements, solvency, and financials of physician practices and organizations. Many of them rely on a mix of payment arrangements, including capitation, shared savings, shared savings and losses (upside and downside risk), and fee-for-service. Payment mix depends in part on specialty — primary care physicians are more likely to be responsible for a defined panel of patients and to be paid on a population basis than are specialists. Limited information is available on the share of physician practice revenue generated by each payment type. A recent analysis of physician compensation in 31 nonprofit US health systems, half of them in California, found that volume-based payment was prevalent for both primary care physicians and specialists. Salary, capitation, and profit-sharing were also observed to a varying extent, and incentive payments based on quality and cost performance were common, particularly for primary care physicians.[54]

Three types of physician practices and organizations that coexist with RBOs and restricted licensees but do not have the same registration and reporting requirements are described briefly below: RBO "Look-Alikes," physician practices and organizations that accept capitation but do not make payments to downstream providers, and practices that accept only fee-for-service payment.

RBO "Look-Alikes." Some physician organizations meet the three-part test of an RBO (contract with a plan for a defined population, accept capitation, and pay downstream claims) but are exempt from the RBO definition by statute or have received a DMHC determination that they do not meet the definition due to their organizational structure, ownership, or other characteristics. The DMHC makes such determinations on a case-by-case basis.

While a complete list is not available, some notable exemptions and exclusions include these:

- Statute exempts physician organizations that exclusively contract with a single plan, an exemption that currently applies only to Kaiser Permanente's two medical groups: The Permanente Medical Group (in Northern California) and the Southern California Permanente Medical Group.
- DMHC has determined that the University of California medical groups do not meet the RBO definition. There are six UC health systems: UC Davis, UC Irvine, UCLA, UC Riverside, UC San Diego, and UCSF.

Collectively, these exemptions represent millions of covered lives in California. In fact, enrollment in RBO Look-Alikes exceeds enrollment in RBOs. Kaiser Foundation Health Plan (and therefore Kaiser's medical groups, given that they contract exclusively with the health plan) had just over 9 million enrollees in 2021, compared with the 8.8 million enrollees reported by all RBOs combined. As noted in Table 2, according to Cattaneo & Stroud's most recent summary report on active medical groups, UC and county groups accounted for 1.5 million enrollees.

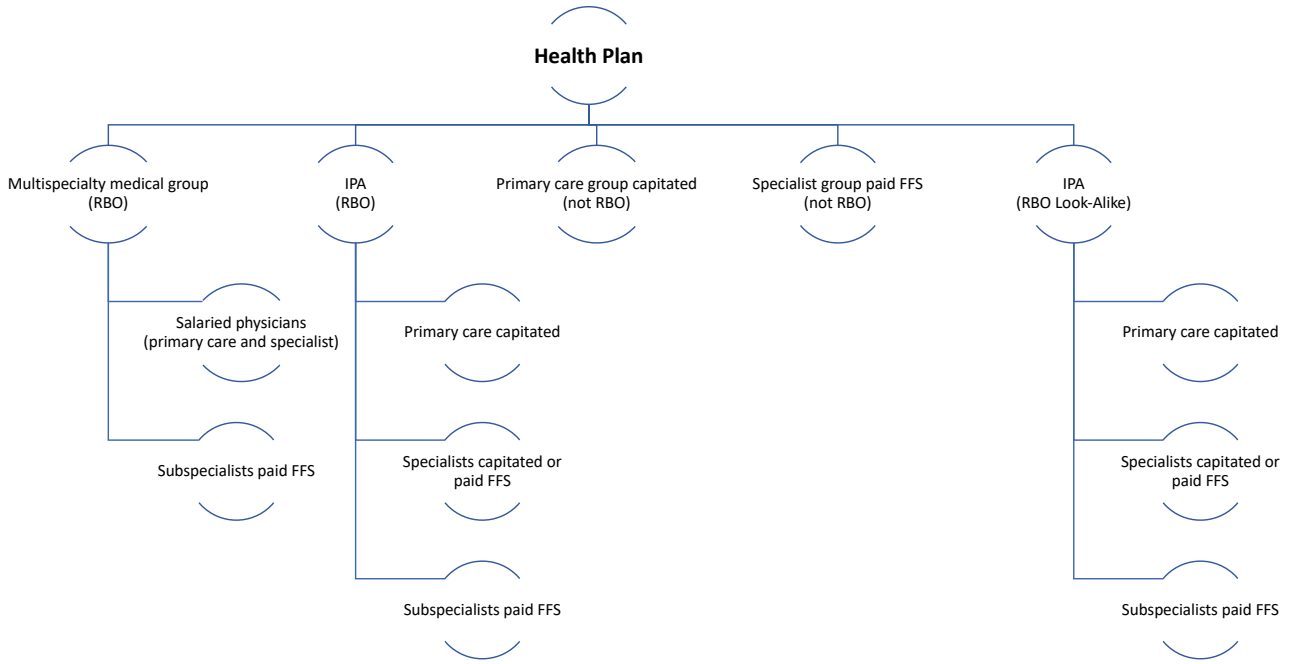
The limited information DMHC receives about RBO Look-Alikes is gleaned from annual health plan claims settlement reporting, filed annually by health plans. In the claims settlement reporting, health plans identify contracting entities, including physician organizations, that pay delegated claims. The DMHC can compare this list to the registered RBOs to determine the organizations that accept capitation and pay downstream claims but are not classified as RBOs.[55]

Practices that accept capitation but do not make downstream payments. One of the tests of an RBO is payment of downstream claims or subcapitation. Some physician practices accept capitation, but only for services provided within their four walls (physical or virtual). The contracting entity, whether a licensed health plan or registered RBO, bears the risk for services not provided by the capitated physician practice. Comparing a primary care group to a multispecialty medical group illustrates the difference. Many multispecialty medical groups accept capitation for the full range of professional services, but when subspecialty services are needed, they rely on specialists outside the medical group and pay them on a fee-for-service (FFS) basis (downstream claims). By contrast, primary care physician groups may choose to manage financial risk by accepting capitation only for primary care services; when specialty or subspecialty services are needed, the specialists are paid by the health plan (or contracting RBO). Accepting capitation without paying downstream claims is common in primary care groups and can also be found in some specialty areas. Because these organizations are not required to register or report, it is not known how large this group is.

Practices that rely solely on fee-for-service payment. No comprehensive data are available on physician practices in California that rely solely on FFS payment.

Exhibit 2 illustrates some of the contracting arrangements and categorization among various types of physician organizations and practices, including RBOs, RBO Look-Alikes, primary care groups that accept capitation but do not pay downstream claims, and specialist groups paid fee-for-service. A health plan may contract with an array of physician organizations and practices through a wide

Exhibit 2. Illustrative Example of Contracting Arrangements



Note: *FFS* is fee for service; *IPA* is independent practice association; *RBO* is risk-bearing organization.

Source: Jill Yegian and Marta Green.

variety of payment arrangements. In turn, physician organizations and practices that accept capitation on behalf of a defined patient population may pay providers through capitation or fee-for-service. The diagram is much simpler than actual contractual relationships and payment arrangements, which often include performance incentives and other provisions such as shared risk.

Management Services Organizations

The framework is incomplete without mention of MSOs, though they are not physician organizations. Due to California's ban on the corporate practice of medicine, MSOs may not own physician organizations, and their role is restricted to nonclinical decisionmaking. However, the scope of MSOs can include clinical guidelines and programs, clinical operations, and delivery of programs such as home care.[56]

MSOs have grown in number, size, and importance in the physician organization market. For example, Network Medical Management (NMM) provides administrative and related services to over a million lives in 16 IPAs, as well as accountable care organizations in the commercial and Medicare markets; ApolloMed, NMM's parent company, is publicly traded. Another large MSO, the privately held MedPOINT Management, has similar scale: over a million lives in 18 managed groups, most of them focused on Medi-Cal managed care. MedPOINT serves as the MSO for both Health Care LA IPA and Integrated Health Partners, networks of Federally Qualified Health Centers in Los Angeles and San Diego.[57]

There are no registration or reporting requirements in place for MSOs, so information on their number, size, and ownership or contractual relationships is limited. Some information is available through the DMHC RBO data, shown in Table 7 (see page 22). In 2020, 155 RBOs reported using an MSO. Thirty-five MSOs each served one RBO; the other 25 MSOs managed between two and 10 RBOs. Most of the RBOs using an MSO are relatively small, but several RBOs with over 200,000 enrolled lives reported using an MSO. The information on MSOs that comes through the RBO statements is incomplete; many of the entities managed by MSOs are not RBOs and so do not appear on this list. Cattaneo & Stroud's report *Active California Medical Groups by MSO*, last published in 2019, includes 207 MSOs managing 318 physician organizations and accounting for 21.1 million enrollees.[58]

Table 7. MSO, by Number and Size of Contracted Risk-Bearing Organizations, California, 2020

	NUMBER OF RBOs CONTRACTED, BY RBO SIZE				
MANAGEMENT SERVICES ORGANIZATION (MSO)	<5,000	5,000–99,999	100,000–199,999	200,000+	TOTAL
ProSource/MHM	10				**10**
Conifer Value Based Care	2	7			**9**
MedPOINT Management	2	5	2		**9**
Network Medical Management	2	3	2	2	**9**
EPIC Management	3	5			**8**
HealthSmart Management Services Organization	3	4			**7**
Prospect Medical Systems	3	3		1	**7**
CareAccess MSO	6				**6**
Elite Care Health Organization	3	3			**6**
North American Medical Management California	1	4		1	**6**
Procare MSO	6				**6**
Physicians Datatrust	3	2			**5**
S & S Management	5				**5**
Advanced Medical Management	1	1		1	**3**
Identity MSO		3			**3**
PremierOne Plus MSO	3				**3**
All Care To You	2				**2**
Alpha Medical Management	1	1			**2**
AppleCare Medical Management		2			**2**
Change Healthcare Holdings	1	1			**2**
Desert Physicians Management		2			**2**
MSO of Southern California	1	1			**2**
Pacific Health MSO	1	1			**2**
PIH Health Physicians	1	1			**2**
Southern California Physicians Managed Care Services	1	1			**2**
35 additional MSOs, each serves one RBO	7	18	7	3	**35**
Total	**68**	**68**	**11**	**8**	**155**

Source: Author analysis of RBOs' "**Statement of Organization**" (2020), California Dept. of Managed Health Care.

The Path Forward

Existing sources create an incomplete picture of California's complex and rapidly changing physician landscape, without systematic capture and reporting on structure, affiliation, ownership, and payment arrangements. Significant gaps in information suggest that it may be worth considering measures to increase availability of data to support policymaking, practice, and research that can enable improvement in affordability and health system performance. Despite limitations, DMHC's RBO data have several distinct advantages: Submission is legally required for entities meeting the RBO definition, it is collected quarterly and annually, and DMHC makes some of the data publicly available. From that perspective, it represents a bright spot in a challenging data terrain.

Any policy conversation regarding accountability for cost, quality, value, and equity would benefit from a more complete inventory of physician practices and organizations in California. Moreover, given the fluid nature of physician affiliation, an essential feature of any inventory must be regular updates — static, onetime data collection efforts are quickly rendered obsolete in a dynamic market. However, given that reporting requires resources, any new requirements should have a clear rationale, and the benefits of new information should be assessed against the reporting burden.

Should registration and reporting requirements be extended beyond RBOs to other types of physician practices and organizations? Could health plan reporting requirements, such as existing network adequacy standards and anticipated standards for quality and equity, be adapted to fill information gaps in lieu of additional physician practice reporting? Should MSOs be required to register and report? Should summary financial information be required reporting for all physician practices and organizations, such as the share of revenue spent on medical care (analogous to a health plan's medical loss ratio)? The answers to these and other questions should flow from a statewide vision and agreement on priorities for data on the physician practice landscape in California.

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