Risky Business: Erosion of the Commercial Delegated Model in California

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Risky Business: Erosion of the Commercial Delegated Model in California

There are grave risks to the survival of our California infrastructure of physician-led delegated, capitated health care[1]. This paper outlines the steps that California policymakers should take to save the non-Kaiser[2] delegated delivery system from extinction in individual and small group commercial products.

The decades-long struggle with health care cost control has been an effort to identify the proper incentives that influence the care decision-maker, whether clinician or staff, directing them to do the right thing for the patient in the most economical and efficient manner. When health care pundits describe an optimal system they always invoke a *coordinated, financially accountable care* model.

Recently, the *Berkeley Forum Group*[3], convened in 2012 and 2013 and composed of many of the most engaged and experienced health plan and policy leaders in the state, strongly advocated for the advancement of integrated, accountable care networks to achieve better, more sustainable health care. Further, the recently published California State Innovation Model[4] grant presentation, a project worked on for several years by California's leading health policy and practice thinkers, also advocated to strengthen the integrated delivery system as a priority.

At a national policy level, Accountable Care Organizations (ACOs), based on aligned financial incentives such as capitation, are touted as the path to achieve "Triple Aim"[5] results in our patient care. This is in recognition that traditional models of health care financing and delivery have multiple drawbacks that often lead to expensive, reactive-rather-than-proactive care, drawbacks such as coverage denials that may harm patient health and gaps in care when patients move between settings.

In California, the past five years have evidenced a dramatic move of MediCal patients from fee-for-service into managed care models, with health plans delegating and capitating medical

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[1] Under a delegated, capitated model, a health plan or payer delegates its responsibility to provide delineated care management services in exchange for a fixed, advanced per member per month flat fee.

[2] California's HMO (health maintenance organization) powerhouse of Kaiser owns approximately 40% of the market share in the California commercial market.

[3] The Berkeley Forum was a year-long collaborative effort involving policy experts from the University of California, Berkeley, CEOs of major health insurers and health care delivery systems, and leaders from California's public sector, which produced a detailed roadmap to transform the state's health care system.

[4] The California State Innovation Model (CalSIM) Design grant was received in 2014. 6 private sector work groups were convened to flesh out the six goals of the state's "Let's Get Healthy California" initiative.

[5] The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance on three dimensions, called the "Triple Aim": Improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

groups to arrange for and provide the actual care. Patient and provider satisfaction rates are relatively high given the mandatory nature of the move and continuing concerns over the low MediCal rates. The MediCal expansion, as well as the integration of members eligible for both Medicare and MediCal, relies upon the structural integrity of managed care and California's coordinated capitated system.

The California health care market includes a large number of organizations that already have the physician leadership, administrative capacities, financial management skills, and clinical programs needed to become commercial ACOs or other risk-bearing entities. For integrated medical groups, this national and state embrace of risk-based contracting would seem to broaden the path in commercial coverage to being paid for doing what the groups do best: coordinating care and managing costs.

Yet here we are in late 2014, in the cradle of delegated managed care, noting:

- A precipitous decline in commercial enrollment in non-Kaiser delegated HMO products
- Covered California (the exchange) releasing a second round of product choices that strongly advantage Preferred Provider Organization (PPO) and Exclusive Provider Organization (EPO) products with narrow networks
- The near-absence of competitive HMO products on the Exchange, other than Kaiser
- Self-funded employers increasingly moving away from the comprehensive HMO product, in favor of the flexible PPO product platform
- Health plans increasingly disfavoring the physician-led delegated model in favor of hospital-led potentially non-scalable ACOs, including Anthem's newest seven-hospital collaboration, Vivity[6] in Southern California.

It is time for our state health policymakers to help shape a different course that preserves the state treasure of coordinated, capitated care that Californians have enjoyed over the last 20 years. To not attempt to remediate the obstructions to the success of the delegated model through considered law and policy would be extremely short-sighted. Also, a large-scale meltdown of California's model due to eroding finances would hold serious implications for the California's MediCal managed care strategy and for national health policy advancement of physician-led, coordinated and accountable health care.

This corrosive effect will mean that the benefits of true "managed care" will increasingly be unavailable outside of Kaiser and a few other systems to middle-class, commercial patients in California. First, individual and small group member products in the Exchange will be unlikely to have a capitated medical group assignment linked to their now PPO, not HMO, product. Second, the lack of upfront capitated payments means sharp declines in the capital dollars necessary to build the care system infrastructure, ranging from primary care to specialty care to hospital and home-based care.

[6] Anthem Blue Cross and seven top hospital systems have partnered to offer Anthem Blue Cross Vivity, an integrated health system in Los Angeles and Orange counties. This is a first in the nation partnership between an insurer and seven competing hospital systems that will align to share financial risk and gain.

Policymakers cannot rely solely on health plans to ensure that the solid framework of California's coordinated care model remains available for future Californians. For example, if publicly traded, these plans are required by law to represent the short-term interests of shareholders. Further, health plans are largely trying to design products that meet a current market niche; they are not and do not believe that they are accountable for advancing population health.

Successes of the California Delegated Model

California has traditionally had the highest commercial HMO enrollment in the country, with Kaiser holding a 40% market share. The delegated model – under which organized groups of physicians accept responsibility for managing the care of HMO enrollees – has arguably been California's preferred system for delivering health care. The delegated model is based on the premise that delivering care through well-managed physician groups with delegated health plan responsibilities puts decision-making into the hands of physicians and closer to the patient, producing better coordinated, higher quality care. If delegated groups are paid through a fixed "per-member, per-month fee," called "capitation," they are also called "risk-bearing organizations" (RBOs) and are overseen by the California Department of Managed Health Care (DMHC).

Most of the HMO health plans' care responsibilities have historically been delegated to more than 200 delegated medical groups and independent practice associations (IPAs). The delegated model groups historically operate in three product areas: Medicare Advantage HMO, commercial HMO and MediCal Managed Care. Regulatory constraints limit RBO engagement in the self-insured market and PPOs.

Capitation has overall been a success in a properly structured environment. In contrast with many accountable care experiments around the country, California's delegated, and capitated model is an actual proven *system*, not a one-off experiment whose advantages may, or may not, be replicable on a large, complex scale.

The best performances of California's delegated, capitated groups are properly celebrated:

- The results of the California Association of Physician Group's annual *Standards of Excellence*© [7] survey among CAPG members document the impressive breadth and depth of care management, HIT, accountability, and patient care infrastructure that exists among California's coordinated care model. Among the higher performers, the overall utilization rate for care and quality results is better on a larger scale in California than anywhere else.[8] The *Standards of Excellence* program establishes a national

[7] The survey helps set the bar for healthcare consumers to evaluate a physician group's technical quality, its responsiveness to the patient experience and its affordability. CAPG believes this initiative has documented the impressive breadth and depth of care management, HIT, accountability, and patient care infrastructure necessary for the coordinated care model to establish a national blueprint for excellent, accountable care and strengthened our culture of transparency, measurement, and reporting, complementing the efforts of pay for performance.

[8] Examples include hospital admissions, ER visits, readmissions, complications of diabetes, missed school days for asthma, falls in the elderly, medication errors, avoidable inpatient complications, and many more.

blueprint for excellent, accountable care that can meet the escalating expectations of healthcare purchasers and patients.

- Efficiency measures in the California Medicare Advantage products report less time in the hospital under coordinated care versus original Medicare.[9]

- California's Jamie Robinson has reported in a recently published study[10] that, from the perspective of the insurers and patients, between 2009 and 2012, physician-owned organizations incurred lower total costs of care than hospital-owned physician organizations in California for professional, hospital, laboratory, pharmaceutical, and ancillary services.

- The value of California's coordinated care model has been best evidenced in patients with multiple conditions. Programs in which care managers had in-person interactions with patients and coordinated closely with physicians were more likely to reduce hospital admissions.[11]

Pushback from the Health Plans

The rejoinder by health plans and even brokers to these successes is that the delegated model has become bloated, increasingly inefficient and non-competitive. It is not news to report that the performance among groups is uneven. Further, complacency towards the commercial market erosion inhibits action. Medicare Advantage has been a huge boon to the medical groups and has distracted them from the long-term implications of the declines in commercial capitation. Many medical groups have become content with high Medicare Advantage capitation rates and seem dispassionate about the decline in commercial lives under capitation.

Insurers report that the vaunted efficiencies of the delegated HMO product have disappeared. For example, one California health plan states that their PPO is outperforming the HMO product in bed day metrics, citing 16% more efficiency. They believe that they are better able to perform medical management in their PPO product to control hospital utilization than in their HMO product. Another plan states that the delegated model is not producing value in either quality or cost trend.

While taking the sincerity of these claims at face value, there remains a valid question as to whether these are apples-to-apples comparisons. Certain factors suggest otherwise:

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[9] CMS & SDI, 2012. Compiled by Managed Care Digest Series. 2,000 patient days per hospital vs. coordinated care California MA model at 800 days/thousand

[10] *JAMA. 2014; 312(16):1663-1669.* Researchers found that medical costs were 19.8% higher at medical groups owned by large health systems, compared with a physician-owned group. Meanwhile, costs for local hospital-owned groups were 10.3% higher than independent physician groups. Lead author James Robinson said the higher costs can be attributed to the expectation that physicians admit their patients to the higher-priced hospital that has acquired their medical group.

[11] *Complex Puzzle: How Payers Are Managing Complex and Chronic Care*, CA Healthcare Foundation, April 2013

- The draw to the HMO product by sicker patients because of the lower cost-sharing at the point of care.
- The chilling effect of high deductibles – lower utilization may be a symptom of "sticker shock" versus the known positive effect of stronger care management
- The inability to "true up" the HMO and PPO products in California given the uneven regulatory floor.
- No accountability or reliable record of quality performance on the PPO product, while HMO performance is scrutinized annually.[12]
- The frequent reference by health plans to a successful "experiment" involving one or a small number of cherry-picked participants versus judging the California system as a whole, good and bad performers alike.

What should the State do?

One can argue that there is no role for state policymakers to favor one market approach over another. However, that is not the case where the state's heavy thumb on the regulatory scale for HMO products has greatly tipped the advantages to the lesser-regulated PPO products.

California's excessive HMO regulation is frequently cited as a factor in the retreat from capitation. It is irrefutable that California's consumer advocates have pummeled the HMO product, while failing to shape meaningful safeguards in PPOs. This fostered a growing market for PPO products that allowed greater product flexibility and lowered regulatory standards for timely access to care and other protections. Sacramento lawmakers and consumer/union advocates have inadvertently strongly price-advantaged the health product with lesser consumer protections.

Past policymakers have actively created these disadvantages over the last 20 years. Thus, the current administration is now burdened with the task of righting the scales to preserve a system that is a state treasure, particularly for patients with multiple conditions, such as the dual-eligibles.

The challenges loom large in the next few years and call for recommitment to commercial product innovation, re-engagement by payers and groups to resolve technical obstacles, cost control, and "best practice" management by the delegated groups, leadership by Covered California and other private exchanges, and strengthened financial reporting standards and monitoring structure.

There are 10 actions state policymakers can aggressively initiate:

1. **State policymakers must convene commercial health plans and interested parties to re-engage around the affordability and regulatory oversight of HMO delegated products.**

[12] http://reportcard.opa.ca.gov/rc/medicalgroupcounty.aspx

The state must lead a channeled dialogue with purchasers, plans, and policy entities to ensure that the established value of the delegated model is not lost to California consumers. Extremely high deductible products are untenable and will need to be reinvented when they result in unconscionable delays of care, fail to constrain chronic care costs, or prove inadequate to deliver appropriate care to sicker patients. Even for advocates of the Affordable Care Act (ACA), it is time to get frank about this growing healthcare consumer issue.

Further, rosy reports of consumer acceptance notwithstanding, narrow networks are already under intense fire from patients attempting to use their benefits. We are also hearing from advocates who likely understood the Faustian bargain in the Exchange from the outset: high benefits and low premiums require restricted networks. Now, of course, as in the 1990's, the vocal advocacy to have it all has re-emerged: low premiums, great benefits and broad provider networks. As narrow networks fracture under public and legislative pressure, only risk-based payment arrangements, such as capitation, can address these affordability concerns. The state can uniquely drive these discussions.

2. **Policymakers and advocates need to allow the delegated, capitated HMO product to adapt to the changing marketplace of higher deductibles, cost-sharing and narrow networks.**

   The HMO model needs to change to remain relevant and affordable. IPAs and integrated medical groups seek to extend their care management programs to serve a broad spectrum of patients regardless of their insurance coverage: commercial HMO and PPO, Medicare Advantage, traditional Medicare and MediCal managed care.

   State policymakers implicitly understand the value of the delegated, capitated HMO product, as evidenced by the deep penetration of delegated managed care in MediCal. It is essential to bring that understanding, and a sense of urgency, to the commercial HMO market and discuss the necessary product "fixes."

3. **PPO plans must pay for the costly infrastructure that benefits them in California's managed care environment.**

   Prospective payment provides the capital for the care infrastructure that makes efficient coordinated care possible. Capitated patients pay their way and fund non-capitated, discounted fee-for-service patients that receive those benefits without paying for them. Physicians only practice one brand of medicine under the Hippocratic Oath and will never endorse practice methods that distinguish between patients, based upon their coverage. But, at a practice level, they can to some extent turn on or off the system that supports nurse managers, hospitalists, care coordination, and health technology.

   Rather than asking these practitioners to practice sub optimally, to the detriment of all, a better course is to require health plans to support that care infrastructure. An advance payment for care coordination or medical home infrastructure is a better solution, rather than

losing many of the features that enabled the celebrated 10-15% efficiencies between fee for service and managed care. This is an unconscionable system loss.

4. **Covered California policymakers must hold PPO and Exclusive Provider Organization (EPO) products to the high regulatory standards of HMOs on quality reporting.**

   Covered California has laudably more than survived its first marketplace tests and deserves huge kudos for actually pulling off a functional, affordable Exchange. In the second year, Covered California should burnish its role as an active purchaser by demanding greater accountability for quality performance and a mandate for care coordination of its PPO and EPO products. As it is, in its first years of product offerings, there is scant evidence of active coordinated care products on the Exchange, outside of Kaiser. While model contracts exhort the primacy of primary care, there is little accountability currently required of PPO products, again advantaging them in the market.

5. **Policymakers must push health plans to work with medical groups to resolve the inability to administer and track deductibles as a consumer right, not a proprietary advantage.**

   One of the biggest obstacles faced by the delegated groups is the inability to track and accumulate patient deductibles. This is no easy fix. In a capitated world, a patient visit does not create an occasion for reimbursement; therefore, capturing that encounter and coding it optimally have traditionally not been relevant. However, tracking patient contributions towards high deductibles is a consumer protection issue and a community good, not simply a competitive attribute that should be owned by one health plan or one medical group.

   Such “accumulator” technology is apparently more than a “twinkle in the eye” and is in the works, but as of yet still unproven and unsubsidized for implementation. It is also possible that there are off-the-shelf alternatives that are scalable across all health plans and providers. However, the effort to construct an accumulator has languished from lack of support from health plans, except Health Net. Feet should be held to the fire to develop this solution.

6. **The state should require health plans to work with medical groups, to be able to contribute meaningful data to employers for reporting, and to health plans, for risk adjustment and cost-sharing purposes.**

   Risk adjustment will continue to be perhaps the most vital element for insurers' success on the exchanges. The ACA's requirements that all insurers participate in a state and/or national pooling of risks and reallocation of profits and losses sets up continued competition in the zero-sum system to annually demonstrate highest risk patients. Perversely, risk adjustment may encourage fee-for-service medicine and “optimal” or up-coding. That portends a serious corrosive effect on California’s health care costs.

Delegated groups must also be able to better prove their value through improved quality and lower cost metrics. The Standards of Excellence survey and Integrated Healthcare Association's Pay-for-Performance recognition programs are outstanding accountability efforts. These metrics, however, must align with the quality reporting requirements imposed on health plans.

7. **The DMHC should develop a formalized license structure that supports ACO direct contract arrangements with local and regional employers**.

   There is a rapidly developing federal policy on "ACO 2.0" that includes "global payments" to such entities. Employers could then partner with a local capitated mainstream delivery system to synchronize workplace health promotion programs with the delivery system featuring information flow and collaboration. Such an arrangement would require state licensure, expanding limited licenses, and would create a category of full-risk bearing entities between a full-service plan and an RBO. As California has led in other areas of the ACA implementation, this is another opportunity to protect our state asset and support a multiplayer strategy for such entities.[13] Expansion of the limited license regulation[14] would recognize prior "limited" and "restricted" licensees in good standing on the effective date of the new rule. Limited licensees would need protection from health plans canceling other contracts as retaliation for direct contracting with employers.

8. **Federal policymakers should acknowledge that Medicare Advantage payments must reflect the reality of the need for cross-subsidization between the federal Medicaid and Medicare programs.**

   In California, as in many states, Medicaid pays providers at such low rates than many patients find it difficult to find a doctor willing to see them for timely care. Some opine that the "duals" initiative is an effort to shore up Medicaid by subsidizing it with Medicare dollars, reflecting the reality of the need for cross-subsidization, in which a higher-profit product subsidizes the lower-paying product. Similarly in Medicare Advantage, CMS should not squeeze out the entire excess premium and should implicitly acknowledge that cross-subsidization of Medicaid rates is an essential market function and a role that the private commercial insurance market is no longer willing to play.

9. **MediCal Managed Care (MMC) Plans must be required to pay out 85 percent of their premiums in capitated payments.**

[13] ACO License: The Pioneers had limited licenses from the DMHC or acquired them in advance of downside risk in year 3.

[14] History of the Limited Risk License: The DMHC and its predecessor agency, the Department of Corporations, have licensed several "limited" and "restricted" entities over the years. Such licenses allow the licensee to accept both institutional and professional risk-based payments as subcontractors to full-service plans. These restricted plans also are referred to "plan-to-plan" licensees, because by stipulation with DMHC, they are allowed to only do business with other plans (no direct marketing or contracting with the governments).

Federal law requires all commercial health plans and insurers to comply with a strict 85 percent medical loss ratio (MLR); MMCs are not included in this requirement. The California Department of Health Care Services (DHCS) imposes the 85 percent MLR rule by contract to all of its plans, and has the Department of Managed Health Care conduct reviews through an interagency agreement. But DMHC does not have jurisdictional authority to enforce in this area; it can only refer comments to DHCS for follow-up. CAPG members have discovered information that leads them to conclude that some MMC plans are operating their MediCal managed care business at perhaps a 70-75 percent MLR. They have raised this issue with the DMHC to seek verification. If this is true, it is essential public policy that when public funds are expended, there must be accountability to loss ratios that ensure that premium dollars are available for health services, not administrative costs and profit.

10. The DMHC should strengthen its fiscal oversight of shared risk requirements negotiated by MMC plans

MMC plans increasingly require physician and hospital partnering as a pre-condition to obtain capitated lives, using shared risk pools between delegated physician groups and hospitals. Pools are frequently underfunded and may dry up quickly. The word on the street is that hospitals are often demanding backfill from the capitated group or threaten to pull out of the arrangement, causing the group to lose its assigned lives. Backfilling a deficient risk pool for hospital costs is akin to taking institutional risk without a license approved by the DMHC to assume risk. There must be greater oversight by the DMHC of financial conditions than currently exists for RBOs that are part of such shared-risk pool arrangements.

Capitation success is not just a physician responsibility. To avoid the problems of the past, health insurers must treat physicians as equal partners. They must freely share accurate and timely patient enrollment and utilization information with physicians, so that physicians can perform the types of pre-contract and ongoing analyses essential to succeeding under capitation. In the commercial realm, it will be difficult but essential to retool DOFRs[15] for high cost-sharing products with limited “first-dollar” benefits[16]

Conclusion

While this paper focuses on policymakers, it is essential that capitated groups get seriously engaged in the survival in the commercial product. As Medicare Advantage margins wane, it is crucial that physician organizations become more nimble and responsive to the new commercial marketplace and how they can deliver value for their share of the health care dollar. Groups need to roll up their sleeves, drive waste and duplication out of their systems and think intently about the future and whether it will include private payers. Critical to this exercise is the development and implementation of a strategic framework to guide performance and culture.

Providers and insurers must jointly recognize the need to recreate a more competitive and sustainable cost-effective delivery system that can be competitive in a high-deductible PPO product environment. However, without the engagement of California and federal market

[15] A DOFR is the contractual *division of financial responsibility* between the health plan and medical group.
[16] First-dollar benefits are those services, such as preventive services, to which upfront deductibles do not apply.

makers, efforts by the delegated groups alone simply cannot save the delegated model. Policymakers must help to shape a different course that preserves the state treasure of coordinated, capitated care in California. As stewards of vital community health resources, this approach will provide the foundation for ensuring access to accountable, competent care.