



Accountable Care Organization in California: Lessons for the National Debate on Delivery System Reform

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Overview

- IHA white paper
- The California ACO Ecosystem
 - Organizations and patients
- Key Lessons from 30 years of experience
 - Organizational structure and ownership
 - Payment methods
 - Provider coordination and consumer choice
 - Financial solvency regulation
 - ACOs and under-served populations



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The California ACO Ecosystem

- Many cities and states have one or a few organizations that may be or become ACOs
- But California has 30 years experience with several hundred prepaid physician groups and physician-hospital systems
- These organizations serve commercially insured patients (mostly HMO), plus Medicare Advantage and Medicaid managed care
 - What has been learned?
 - How can we inform the national ACO policy debate?



Types of Organizations

- Types of Physician Organizations
 - Kaiser Permanente
 - Other integrated multi-specialty medical groups
 - Independent Practice Associations (IPA)
- Relationships with hospitals
 - Hospital owns medical group ('Foundation model')
 - Medical group is closely aligned with but not owned
 - Medical group uses multiple hospitals, is not aligned



Types of Payment

- Capitation (per member per month)
 - Professional services (primary and specialty physician)
 - Global (physician and hospital)
- Pay-for-performance
 - Process and outcome measures of quality
 - Patient experience
 - Information technology adoption and use
- New payment initiatives
 - Shared savings bonus based on efficiency (cost of care)
 - Episode-of-care payment



The Distribution of Patients (HMO Enrollees) across Types of Physician Organizations

Type	Number of Organizations	Total HMO Enrollees	Commercial HMO Enrollees	Medi-Cal HMO and Healthy Families Enrollees	Medicare HMO Enrollees
Permanente Medical Groups¹	2	6,659,879	4,879,844 (73%)	308,236 (5%)	740,173 (11%)
Integrated Medical Groups²	131	4,425,100	2,682,600 (61%)	1,305,150 (29%)	437,350 (10%)
IPAs	152	4,849,200	2,629,250 (54%)	1,843,250 (38%)	376,700 (8%)
Total³	285	15,718,350	10,751,850 (68%)	3,447,150 (22%)	1,519,350 (10%)

There are two Permanente Medical Groups that serve Kaiser enrollees in California, one in the north/central region and one in the southern region. Each of these is formed of multiple large sites. These Kaiser enrollment data are from a 2009 Kaiser Foundation Health Plan Financial Summary Report generated on the website of the Department of Managed Care (<http://wpsso.dmhc.ca.gov/flash/>). The enrollment figures do not add up to total HMO enrollment due to the existence of alternate insurance types.

²This includes foundations, medical groups (with or without wraparound components), and community clinics, but does not include Permanente Medical Groups.

³The three previous rows do not add up to totals due to differences in data sources.

Data Sources: Cattaneo and Stroud, "#7: Active California Medical Groups by County by Line of Business, for Years 2004 through 2010, Sorted Alphabetically," May 1, 2010. Provided by W. Barcellona, July 27, 2010; and the Department of Managed Health Care's Health Plan Financial Summary Report Tool (<http://wpsso.dmhc.ca.gov/flash/>).



Patients Who Receive Care from ACOs

Insurance Type	All Types (Total Enrollees)	Commercial	Medi-Cal / Healthy Families	Medicare
ACO HMO Enrollment in CA	15,943,850	11,285,950 (71%)	3,164,000 (20%)	1,493,900 (9%)
Entire Insured Population in CA	29,691,000	20,110,800 (68%)	6,036,300 (20%)	3,308,800 (11%)
ACO HMO Enrollment as a Percent of Total Enrollment	54%	56%	52%	45%

Note: The total insured population is larger than the sum of the total commercial, Medi-Cal and Medicare enrollees due to the presence of other types of insurance (e.g. TRICARE).

Data Sources: Cattaneo and Stroud, "#7: Active California Medical Groups by County by Line of Business, for Years 2004 through 2010, Sorted Alphabetically," May 1, 2010. Provided by W. Barcellona, July 27, 2010; and Kaiser Family Foundation, "California: Health Insurance Coverage of the Total Population, states (2007-2008), U.S. (2008)." Statehealthfacts.org, 2009. <http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=6&ind=125&sub=39>. Accessed on July 15, 2010.



ACO in California: Key Dimensions

1. Organizational structure: groups, IPAs, hospitals
2. Payment methods: capitation, FFS, blends
3. Coordinated care and consumer choice
4. Financial solvency regulation
5. Special focus on under-served populations



1. Organizational Structure and Size

- Both integrated medical groups and IPAs can be successful, and neither is displacing the other
- Ownership by a hospital system can be successful but many medical groups remain independent
- There is a full range of organizational sizes, with only a modest trend towards consolidation
- Kaiser Permanente has unique and successful structure that is very difficult to replicate



Distribution of Medical Group Size, 2009

Total Enrollment Range	Number of Groups	Percent of Total Enrollment
< 5,000	73	1%
5,000-9,999	40	2%
10,000 – 14,999	35	3%
15,000 – 24,999	44	5%
25,000 – 49,999	31	7%
50,000 – 99,999	38	16%
≥ 100,000	24	66%
Total	285	100%

Note: Some ACOs serve considerable PPO, Medicare FFS, Medi-Cal FFS, and/or uninsured patients, which are not included in these numbers

Data Source: Cattaneo and Stroud, "#7: Active California Medical Groups by County by Line of Business, for Years 2004 through 2010, Sorted Alphabetically," May 1, 2010. Provided by W. Barcellona, July 27, 2010.



Organizational Structure: Lessons

- What is important is the set of capabilities
 - Financial management and discipline
 - Culture of cooperation and leadership
 - Clinical information technology
 - Care management processes and programs
- These are essential for:
 - Accepting capitation payment
 - Coordinating care for population of patients
 - Reporting performance to stakeholders



2. Payment Methods

- Major differentiator of medical groups in CA v. US is important role of capitation
 - This drives efficiency but also transfers risk
 - Turbulence of medical group finances
- Narrowing scope of capitation
 - Retreat from hospital and pharmacy capitation
 - This reduces risk but also incentive to manage the full continuum of care
- Medical groups accept risk for a broad scope of services but limit risk transfer to individual MDs



Payment Methods: Lessons

- Capitation works well for ACOs that are sophisticated clinically and financially
- Scope of services that are capitated should be allowed to vary across different ACOs
 - Many medical groups have renounced capitation for hospital and drug services
- Capitation for the ACO can be accompanied by non-capitation for individual physicians (salary in integrated groups, FFS in IPAs)



3. Coordinated Care and Consumer Choice

- Medical groups emphasize coordination of care by channeling referrals within the group, but many consumers value broad choice of physicians at the time of care and do not accept 'gate-keeping'
 - Why would an ACO accept capitation risk or shared savings payment for a defined population of patients if those patients could receive services from providers outside the ACO (which would reduce payments to the ACO)?
- ACOs in CA mostly have served HMO enrollees, but many employers are shifting to PPOs due to their lower premiums (and higher cost sharing requirements)



Trends in HMO Patient Enrollment, 2004-2009



Insurance Type	All HMO Insurance ¹	Commercial HMO	Kaiser ²	Medi-Cal HMO/ Healthy Families	Medicare HMO
Medical Group HMO Enrollment, 2004	15,577,370	6,644,280	6,461,779	2,305,290	720,800
Medical Group HMO Enrollment, 2009	15,718,350	5,311,850	6,659,879	3,148,400	814,400
Percent Change in Medical Group HMO Enrollment, 2004-2009	1%	-20%	3%	37%	13%

¹This column does not equal the total of the ensuing columns due to the use of a different data source for Kaiser enrollment data.

²Kaiser includes all enrollees in Permanente Medical Groups, regardless of insurance type; these enrollees are *not* included in the other categories of insurance.

Data Sources: Cattaneo and Stroud, "#7: Active California Medical Groups by County by Line of Business, for Years 2004 through 2010, Sorted Alphabetically," May 1, 2010. Provided by W. Barcellona, July 27, 2010; and the Department of Managed Health Care's Health Plan Financial Summary Report Tool (<http://wpsso.dmhca.ca.gov/flash/>).

Coordination and Choice: Lessons

- A major challenge facing the ACO movement is how to balance the virtues of provider coordination with the virtues of consumer choice
 - Analysts are developing ‘attribution logics’ to link physicians to patients for PPOs, but will this lead to providers taking responsibility?
- ACOs must learn to provide preventive and chronic care services even to patients facing high deductibles and other cost sharing



4. Financial Solvency Regulation

- Capitation motivates efficiency but also increases financial risk for medical groups
 - Business risk and insurance risk
- Major turbulence 1999-2003 when groups believed in economies of scale, accepted low payment rates and expanded very quickly via mergers
 - 79 groups went bankrupt, affecting 4 million patients
- Since 2002, there has been major decline in turbulence
- Stronger regulation of financial solvency
 - Required disclosure of selected financial ratios
 - Required financial reserves



Regulation: Lessons

- Large physician and hospital organizations that accept capitation payment must develop financial discipline and reserves
- California has extended some forms of insurance regulation to apply to medical groups, and financial turbulence has declined dramatically
- The key is finding the right balance of appropriate regulation that does not stifle the creation of ACOs, but which weeds out the weaker ones



5. Focus on Under-Served Populations

- Medicaid in California relies heavily on safety net organizations and IPAs to provide services
- Like other large states and regions, California exhibits wide geographic variation in demographics, income, access to care
- The ability of ACOs to deliver high quality and efficient care depends on their economic environment



Medicaid Managed Care Patients in ACOs



Medi-Cal/ Healthy Families Enrollees as a % of Group Enrollment	Number of Groups	Number of Medi-Cal/ Healthy Families HMO Enrollees	Percent of Medi-Cal/ Healthy Families HMO Enrollment
0%	77	0	0%
>0-9.9%	51	394,700	11%
10-24.9%	12	131,600	4%
25-49.9%	18	90,950	3%
50-79.9%	22	546,000	16%
80-99.9%	55	1,584,400	46%
100%	50	699,500	20%
Total	285	3,447,150	100%

Data Source: Cattaneo and Stroud, "#7: Active California Medical Groups by County by Line of Business, for Years 2004 through 2010, Sorted Alphabetically," May 1, 2010. Provided by W. Barcellona, July 27, 2010.

Geographic Variation in ACO Performance



Area Characteristic	Bay Area	Inland Empire
Per Capita Income	\$46,015	\$23,540
Percent Persons of Hispanic or Latino Origin	22.1%	45.7%
Uninsurance Rate	7.8%	15.1%
PCPs per 100,000 residents	79	40
IHA Clinical Quality Score (/100)	76.78	62.10
IHA IT-Enabled Systemness Score (/15)	13.61	7.30
IHA Coordinated Diabetes Care Score (/20)	10.59	2.81

Under-Served Populations: Lessons

- The Affordable Care Act will most immediately expand coverage through Medicaid
- ACO development will be especially important for Medicaid, due to unmet needs and low payments
- Both safety net clinics and IPAs can successfully serve Medicaid patients, even at low payment rates, but struggle to achieve quality, IT, and coordination levels achieved by other ACOs
- Special attention and funding is needed for ACOs that serve traditionally under-served patients



Conclusion

- California has over 250 physician and physician-hospital organizations that receive capitation payment and coordinate care for over 15 million commercial, Medicare, and Medicaid patients
- A variety of organizational structures and payment methods have been used successfully
- One major challenge is to balance care coordination with consumer choice
- Another major challenge is to extent ACO structures to under-served populations
- The national ACO debate has a solid grounding in 30 years of experience

