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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- Special thanks for data collection: Emma Dolan, UC Berkeley
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

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

There are two Permanente Medical Groups that serve Kaiser enrollees in California, one in the northcentral 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://wpso.dmhc.ca.gov/flash/). The enrollment figures do not add up to total HMO enrollment due to the existence of alternate insurance types.

¹This includes foundations, medical groups (with or without wraparound components), and community clinics, but does not include Permanente Medical Groups.

²The 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://wpso.dmhc.ca.gov/flash/).
# Patients Who Receive Care from ACOs

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

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).

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

<table>
<thead>
<tr>
<th>Total Enrollment Range</th>
<th>Number of Groups</th>
<th>Percent of Total Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5,000</td>
<td>73</td>
<td>1%</td>
</tr>
<tr>
<td>5,000-9,999</td>
<td>40</td>
<td>2%</td>
</tr>
<tr>
<td>10,000 – 14,999</td>
<td>35</td>
<td>3%</td>
</tr>
<tr>
<td>15,000 – 24,999</td>
<td>44</td>
<td>5%</td>
</tr>
<tr>
<td>25,000 – 49,999</td>
<td>31</td>
<td>7%</td>
</tr>
<tr>
<td>50,000 – 99,999</td>
<td>38</td>
<td>16%</td>
</tr>
<tr>
<td>&gt; 100,000</td>
<td>24</td>
<td>66%</td>
</tr>
<tr>
<td>Total</td>
<td>285</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

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)
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

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>All HMO Insurance¹</th>
<th>Commercial HMO</th>
<th>Kaiser²</th>
<th>Medi-Cal HMO/Healthy Families</th>
<th>Medicare HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Group HMO Enrollment, 2004</td>
<td>15,577,370</td>
<td>6,644,280</td>
<td>6,461,779</td>
<td>2,305,290</td>
<td>720,800</td>
</tr>
<tr>
<td>Medical Group HMO Enrollment, 2009</td>
<td>15,718,350</td>
<td>5,311,850</td>
<td>6,659,879</td>
<td>3,148,400</td>
<td>814,400</td>
</tr>
<tr>
<td>Percent Change in Medical Group HMO</td>
<td>1%</td>
<td>-20%</td>
<td>3%</td>
<td>37%</td>
<td>13%</td>
</tr>
<tr>
<td>Enrollment, 2004-2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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://wpso.dmhc.ca.gov/flash/).
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

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

### Geographic Variation in ACO Performance

<table>
<thead>
<tr>
<th>Area Characteristic</th>
<th>Bay Area</th>
<th>Inland Empire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Capita Income</td>
<td>$46,015</td>
<td>$23,540</td>
</tr>
<tr>
<td>Percent Persons of Hispanic or Latino Origin</td>
<td>22.1%</td>
<td>45.7%</td>
</tr>
<tr>
<td>Uninsurance Rate</td>
<td>7.8%</td>
<td>15.1%</td>
</tr>
<tr>
<td>PCPs per 100,000 residents</td>
<td>79</td>
<td>40</td>
</tr>
<tr>
<td>IHA Clinical Quality Score (/100)</td>
<td>76.78</td>
<td>62.10</td>
</tr>
<tr>
<td>IHA IT-Enabled Systemness Score (/15)</td>
<td>13.61</td>
<td>7.30</td>
</tr>
<tr>
<td>IHA Coordinated Diabetes Care Score (/20)</td>
<td>10.59</td>
<td>2.81</td>
</tr>
</tbody>
</table>
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
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 extend ACO structures to under-served populations.
- The national ACO debate has a solid grounding in 30 years of experience.