AISHealth.com

Featured *Health Business Daily* Story, April 7, 2015

PPO-ACOs in California Fight to Gain Market Share From HMOs

Reprinted from ACO BUSINESS NEWS, a hard-hitting monthly newsletter with news and business strategies on accountable care, medical homes, bundled payments, coordinated care and integrated systems. Sign up for a $63 two-month trial subscription today.

By Jane Anderson, Editor - April 2015 - Volume 6 Issue 4

California is well ahead of most of the rest of the country when it comes to providers bearing risk in HMO models. But the advent of accountable care organizations and a resurgence in PPO benefit design have led to some unique collaborations between providers and payers in the state, and insurance products based on these alliances are trying to supplant the more traditional HMOs in some areas.

That's the word from speakers who presented March 4 at the Pay for Performance Summit in San Francisco, sponsored by Global Health Care, LLC. They noted that ACO-payer collaborative models hatched in California may not work everywhere else, but nonetheless can hold lessons for organizations in the rest of the country looking for innovative ways to achieve the triple aim.

James Robinson, Ph.D., professor of health economics at the UC Berkeley School of Public Health, told attendees that PPO insurance models — which have become dominant in much of the rest of the country — are on the increase in California as well, and that's put pressure on ACOs and provider groups to adapt.

"We were all moving from fee-for-service to global capitation, but all the employers are going in the opposite direction," he said. "In California, ACO means PPO 2.0."

Pam Kehaly, president of Anthem West Region & Specialty Businesses, noted that it's easier to push a larger share of health costs onto the consumer in a PPO model, and so that's where insurers are going. However, Anthem's innovative Vivity value-based care partnership with seven major Los Angeles-area hospital systems is set up as an HMO, with the partners sharing risk and savings (ABN 2/15, p. 1).

As with other health care markets in the country, hospital acquisition of physician organizations is driving up costs — in 2012, for example, the average total cost of care per patient was a little more than $3,000 annually for patients of physician-owned provider groups, but was more than 50% higher for patients of provider organizations owned by multi-hospital systems, said Robinson.

Meanwhile, high-deductible plans are growing, especially on California's individual health insurance exchange, where bronze and silver plans together represent close to 90% of total plans sold, he said. "Cost-sharing works," Robinson said. "We don't know whether ACOs work, but we know cost-sharing works."

The Vivity model centers the network around major hospital systems, but those systems agree on price and cost targets to achieve market-driven premiums, Robinson said. The ACO model, meanwhile, puts medical groups and independent practice associations (IPAs) at the center of broad PPO networks charged with improving quality and controlling costs, he said. The PPO model allows for benefit designs that encourage judicious use of health care.

Brown & Toland Physicians in San Francisco is a prime example of the ACO model in California, Robinson said.

Richard Fish, CEO of Brown & Toland, a 1,500-physician IPA, told conference attendees that it works hard to form partnerships with payers and hospital providers that take into account where each organization stands on the value-based continuum. Brown & Toland is partnering with a number of different health plans to manage populations of patients, Fish said. "We would consider all our HMO contracts as ACO programs."

The physician organization participates in the Medicare Pioneer program, where it earned $5.34 million in shared savings for 2012 and $2.47 million in shared savings for 2013. The physician organization has "had measurable success on the quality side on our PPO programs," Fish added.

“Lots of hospitals we work with have talked about the goal of supporting lower-cost care, but they’re all in kind of different places,” Fish said. “What we’re seeing is that until the actual transition becomes a big enough percentage of the business model, we’re not really feeling that level of commitment.”

That being said, “we need to meet people where they are,” he said. If a potential partner isn’t quite ready to take on much risk but has a terrific program in one area, then Brown & Toland will work with the partner on just that program. For example, “for hospitals that have a great readmission program, we try to work with that and wrap around it. If they have a great end-of-life program, we work with that and wrap around it.”

Experimenting with benefit design is part of meeting potential partners — in this case, insurers — where they are, Fish said. “It took two to three years to decide we wanted to be flexible enough to support different benefit designs, and it took a year to figure out how to administer a deductible on an HMO product along with the deductible we had on the PPO platform.” But if the organization hadn’t been willing to do that, it would have been at a disadvantage in the marketplace, he said.

For example, Brown & Toland announced a partnership with Anthem Blue Cross on an ACO in 2014, but the two organizations’ initial discussions involved a program that would have looked very different, he said. Providers seeking to partner with payers need to be open to changes, he added. “We’re not just talking about this. We’re actively changing our business models and doing things differently.”

When starting out in accountable care, it certainly helped that Brown & Toland was in California, where the market had demanded disease management and other care management programs for HMO contracts, Fish said. “If we didn’t have any of them, frankly, the ACO shared savings economic model would not have supported us to start,” he said.

Shared Savings Are ‘Not Sustainable’

Shared savings is “transitional” and not sustainable, Fish said. “I don’t think that is going to be a solid enough business model.” Delivery systems won’t be able to count on enough shared savings to make the necessary investments to make the ACO model work, and payers won’t be able to experiment enough in benefit design.

Meanwhile, the seven hospital systems and one insurer that make up Vivity are hoping to turn their partnership into increased market share that’s potent enough to knock back top competitor Kaiser Permanente. Vivity may be a unique partnership; Kehaly says it’s not clear something similar would work elsewhere in the country. But it may have some lessons for other regions nonetheless, she said.

Kehaly said that Vivity falls above ACOs on the provider collaboration continuum, but below fully integrated health systems such as Kaiser and Sutter Health.

The partnership, announced by Anthem last fall, encompasses Cedars-Sinai, Good Samaritan Hospital, Huntington Memorial Hospital, MemorialCare Health System, PIH Health, Torrance Memorial Medical Center and UCLA Health. The seven, along with Anthem, formed a new business entity to implement the Vivity partnership.

Members in the HMO product can see any provider across the seven health systems. Ultimately, the plan is for these hospital systems to clinically integrate, reduce duplicative programs and waste, and refer to each other. Gains and losses will be shared.

“It’s really us aligning around the patient,” Kehaly said. “One of the things the hospitals were very insistent on was that profit doesn’t just get distributed — there has to be a quality component.” Kehaly said Vivity will be considered a success if it can reduce waste in medical care and in health care administration. For example, she said, the seven member institutions have overlapping or even duplicate programs such as concurrent review or 24-hour nurse hotlines. “Do we need to have those separate programs?” she asked, especially when having one program for everyone would make care more efficient and potentially improve quality.

The goal is to turn over various pieces of the health care puzzle to the Vivity member best equipped to handle them, she said. Therefore, the hospital system that’s best at doing joint replacements would handle the bulk of those for Vivity members, while the system that’s best at running a nurse hotline would provide that element.

Integration Gap Is a Challenge

“The challenge we’re going to have is closing the gap between Vivity and the integrated systems above us,” said David Feinberg, M.D., president of Vivity member UCLA Health System. “Can we do that as seven separate providers and one insurance partner so that when a patient comes in to see us, regardless of where they see us, we make sure they get the right care in the right place by the right person?”

Feinberg noted that the seven hospital system members of Vivity have separate data systems and separate cultures. “Can we become integrated in the same way as a Kaiser would be in southern California?” he asked. “That gap is our challenge. Our future is about narrowing that and raising our level of performance. If we can, then I think we really start talking about achieving the triple aim.” Los Angeles is “not a very consolidated market, but this is the beginning of consolidation,” he said. “Entities that have been fierce competitors forever need to look at where they shouldn’t compete.”

Even in California, different market dynamics apply in different regions. Feinberg said he could see Vivity expand to Orange County and San Bernadino over the next few years, but “I’m not sure it makes sense in northern California. It depends on Kaiser’s presence.”

Find this article at:: http://aishealth.com/archive/nabn0415-03

Atlantic Information Services, Inc.
1100 17th Street NW, Suite 300, Washington, DC 20036 - **800-521-4323**