

Accountable Care Organizations in California

*Lessons for the National Debate
on Delivery System Reform*



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TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
INTRODUCTION	5
ORGANIZATIONAL STRUCTURE	6
PAYMENT METHODS	12
RELATIONSHIPS WITH HEALTH INSURANCE PLANS	15
CONSUMER CHOICE	20
PUBLIC POLICY AND REGULATION	20
CONCLUSION	26

EXECUTIVE SUMMARY

Accountable Care Organizations (ACOs) that bring together providers and reward them for controlling costs and improving quality are a major platform for delivery system reform enshrined in the *Patient Protection and Affordable Care Act*. California has 285 physician organizations with many of the characteristics described in the national debate, and its experiences with these organizations over the past thirty years, both positive and negative, offer insight into the challenges that Federal policymakers will face with ACO implementation. This paper outlines five overarching aspects of California physician organizations—their organizational structures, payment methods, relationships with health plans, how they promote consumer choice, and the public policy and regulatory constraints they face—and offers ten key lessons for the national ACO debate.

Lesson One: A variety of organizational structures are effective at delivering high quality coordinated care; at least as important to success as structure are an organization's capabilities, culture, and infrastructure, as well as the alignment of goals between the organization and its individual physicians.

California's physician organizations include Independent Practice Associations (IPAs), multispecialty medical groups, and integrated delivery systems, all of which are being discussed in the national ACO debate. There is no clear evidence that one organizational structure always delivers better care than the others. Instead, what matters are an organization's internal capabilities and market environment, including the presence of strong leadership and organizational culture; clear purpose and shared goals; the sharing of data to help providers reach these goals; performance feedback and accountability for individual providers; participation in external quality improvement incentive programs; advanced care coordination capabilities and the use of coordinated chronic care teams; the use of recommended care management processes for the treatment of chronic illnesses; robust health information technology infrastructure; provider acceptance and use of evidence-based guidelines; and strong market incentives to improve value.

Lesson Two: In California, a range of relationships exist between physician organizations and hospitals. Alignment of incentives between physician organizations and hospitals offer important opportunities for performance improvements across the entire continuum of care.

The national ACO debate envisages a central role for hospitals, but many of California's physician organizations remain independent from hospitals. Compensation methodologies have played a key role in shaping hospital-physician organization

relationships in California; in the absence of joint financial incentives, it is difficult to create alignment between hospitals and the physician organizations that use their services. Closer alignment between physician organizations and hospitals is critical, as a physician organization-centric model cannot bring about the institutional operational changes that will be needed to control overall costs. Hospitals are the highest-cost element of the delivery system, thus including them in initiatives to control costs and increase value is essential.

Lesson Three: As a method of payment, capitation can be effective at encouraging coordinated care, but payment methods should vary across ACOs depending on an organization's ability to assume risk.

Capitation has been vital to encouraging coordinated care by California's providers, as it has forced financial discipline, and allowed for investment in the infrastructure necessary to manage care across the continuum of providers. Fee-for-service (FFS) payments do not offer the same incentive for providers, and it is unclear whether FFS with shared savings—one of the reimbursement strategies that will be used by Medicare in its ACO pilot—will be enough to incentivize providers to transition from volume to value, or to invest in the infrastructure needed for ACOs to provide effective care management. However, accepting capitation payments necessitates that providers shoulder more risk than they currently face, and accepting this risk in steps is advisable in order to maintain stability in the health care sector. California's provider organizations have gone through periods of strength and volatility over the past decades; for example, between 1998 and 2002, there was a great deal of instability in California's health care market that resulted in the closure of 147 physician organizations providing care for 4 million HMO enrollees. Despite this turbulence, a large number of the organizations that emerged continue to assume financial risk for the care they deliver.

Lesson Four: Health plans acting in concert on payment methods and performance measurement helped facilitate the growth of California's provider organizations, and should also play an integral part in fostering ACO development nationally.

Health plans played a key role in the historical development of California's provider organizations. In the early days of medical group formation, plans often acted in concert and adopted similar capitation payment parameters, which lessened the administrative burden on groups, and allowed providers to focus on delivering high quality care to enrollees. Health plans must be ready and willing to foster ACO formation along similar lines, as a critical mass of payers will be pivotal to their success. California's experience with pay for performance (P4P) also highlights the benefits to ACOs of health plans working together. California has the largest non-government P4P program in the country; it includes seven health plans paying performance bonuses to 221 physician organizations based on uniform measures and results aggregated across plans. The aggregation of data across plans enhances data reliability and validity, and has engendered increased provider trust

in performance measurement, as well as collaboration between health plans and physician organizations.

Lesson Five: ACOs are not a panacea for health care spending control.

Some of California's provider organizations have been able to use their market clout to extract high payments from health plans, as the plans' ability to exclude providers from their networks is limited by consumer demand and regulatory network adequacy requirements. Higher-cost and inefficient providers have not faced enrollment penalties because the current California market does not incentivize purchasers or consumers to choose lower-cost or more cost-efficient providers. As ACOs are rolled out across the country, health insurance benefit designs should reward patients for choosing higher-value ACOs, which will necessitate that cost and quality data are available and that consumer cost sharing is higher for less efficient providers.

Lesson Six: ACOs must be agnostic to insurance type; most provider organizations in California have focused on commercial, Medicare, and Medicaid HMO plans for their patients, but for ACOs to be viable across the country, mechanisms must be found to encourage PPO and traditional Medicare and Medicaid patients to use their services.

In California, provider organizations have developed hand-in-hand with HMO products, and have been largely unsuccessful in their attempts to diversify into serving PPO patients. This has been driven in part by regulatory restrictions at both the State and Federal level surrounding providers accepting capitation and FFS payments. Downward trends in HMO enrollment in California have meant that this failure to diversify has limited the impact of the state's physician organizations. In order for ACOs to flourish, laws and policies must allow for innovative provider payment arrangements, regardless of insurance type, and internal organizational changes will be needed to adapt to different payment methods.

Lesson Seven: Balancing patient choice with the desire to decrease costs and effectively coordinate care is difficult. California's experience underscores the challenge of promoting care coordination in an environment of unrestricted provider choice.

Coordinated care leads to better patient outcomes at lower costs, but it also conflicts with the notion of unfettered patient choice of provider at the point of service. For HMO products in California, consumer choice is exercised at the time of insurance purchase, rather than at the time care is sought: consumers choose a plan and, at the same time, a contracted provider organization that coordinates their care. A defined patient population whose per capita costs and quality indicators can be measured and managed is key for physician efforts to improve quality and reduce costs. Efforts to apply care coordination techniques to the open choice PPO environment have not been successful. In addition to encouraging providers to form ACOs, the health insurance market must encourage their use through new consumer cost-sharing arrangements.

Lesson Eight: Regulation of the financial solvency of provider organizations is important to ensure market stability.

California's experience with physician organization failures in the 1990's led the Department of Managed Health Care (DMHC) to institute a Financial Solvency Standards Board tasked with creating solvency standards for provider organizations. Regulations require risk-bearing organizations to file quarterly reports with the DMHC, and to take corrective action if they do not meet specified solvency requirements. Since the early 2000s, the market has become much more stable, which is due in part to this regulation. Bearing financial risk necessarily means that there is a possibility that a provider organization will face financial instability, or even fail, thus there is a need for strong financial solvency regulations to ensure that the health care provider market remains stable, and that patient care is not disrupted.

Lesson Nine: Consumer protections from capitated provider organizations need to be balanced, not overburdening.

While FFS payments can lead to overuse of health care services, capitation payments can incent providers to restrict care. In response to consumer backlash in the 1990s over the perception that managed care led to denials of care, California legislated an Independent Medical Review process, mandated insurance benefits, and network breadth and access requirements for HMO plans. These regulations have helped ensure that consumers are not denied access to services, and that the care provided is comprehensive and timely. However, these regulations have imposed significant costs, and have encouraged the movement of enrollment away from heavily-regulated HMO products to lightly-regulated PPO products and to more self-insured employer arrangements, which are exempt from these state-level regulations.

Lesson Ten: Special attention must be given to establishing ACOs in areas with social and economic challenges.

Statewide physician organization performance measurement in California has uncovered significant variation in the performance of providers, with lower-performing organizations clustered in areas with identifiable sociodemographic and health systems challenges. These variables are interrelated; larger uninsured and Medicaid populations, as well as less consolidation in certain provider markets, lead to lower overall reimbursement, which leaves practices with less capital available for structural and process improvements. Under the new national health reform legislation, coverage will expand most rapidly in these low-income areas, therefore it is important to pay special attention to identifying why quality gaps exist with an eye to setting up high performing ACOs.

INTRODUCTION

Reducing costs and improving quality are becoming increasingly salient concerns in the national health reform debate. Interest is centering on Accountable Care Organizations (ACOs), entities that bring together groups of providers to coordinate care for defined populations of patients, are rewarded for the efficient use of resources, and can report meaningful data on their clinical, financial, and quality performance. The health care system in California is populated by physician organizations that fit the evolving definition of an ACO, and hence provides a robust laboratory for studying ACO performance and obtaining answers to major questions that surround ACO formation. This report summarizes the ACO experience in California and its implications for the national debate over how to encourage organizational structures and payment methods that promote quality and efficiency in health care.



MAJOR QUESTIONS IN THE ACO DEBATE

The contemporary policy interest in ACOs has generated numerous questions concerning how these organizations will be structured, paid, and regulated. In particular, the discussion is open with respect to five key features of an ACO:

- ▶ **Organizational structure:** Which organizational forms offer sufficient promise that they should be promoted by public policy under the ACO rubric: integrated group practices, Independent Practice Associations (IPAs), physician-hospital organizations, and/or others? What is the minimum scale of an ACO in terms of the number of participating patients? What is the appropriate role for the hospital within the ACO?
- ▶ **Payment methods:** Should ACOs be paid fee-for-service with performance-based bonuses, or should payment be moved as quickly as possible to partial capitation and then on to global payment for all health services used by their patient populations? How should payments be linked to performance and budgetary targets to promote cost savings?
- ▶ **Relations with health insurance plans:** The ACO debate has centered on how to restructure care delivery for Medicare beneficiaries, but there are also major potential implications for private health insurance plans. How can health plans structure their insurance products and benefit designs to encourage enrollees to seek care from the most efficient providers, thereby creating fair competition among ACOs? How can methods of quality measurement, reporting, and reward be made consistent across Medicare and private plans in order to reduce the administrative burden on ACOs?
- ▶ **Maintenance of consumer choice:** How does the integration of services within an ACO fit with consumers' desires for choice, and hence with the traditional fee-for-service Medicare program and commercial PPO insurance plans that use

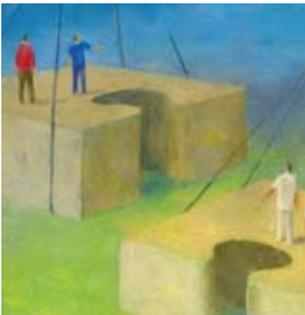
How can health plans structure their insurance products and benefit designs to encourage enrollees to seek care from the most efficient providers, thereby creating fair competition among ACOs?

broad provider networks? What is the relationship between physician incentives, highlighted in the ACO debate, and consumers' incentives, highlighted in previous debates over 'consumer driven health care' and high-deductible health plans?

- ▶ **Public policy and regulation:** Will ACOs face financial instability due to their acceptance of capitation or budgetary limits, and, if so, which forms of financial solvency regulations need to be extended from insurers to these provider entities? Do consumer protection regulations need to be applied to ACOs that are paid prospectively and delegated authority for resource management (and hence have an incentive to reduce the use of services)? What is the appropriate role for anti-trust policy in the face of provider consolidation and potential pricing leverage?

This paper explores California's experiences in each of these areas, and offers ten key lessons for the implementation of Accountable Care Organizations across the nation.

ORGANIZATIONAL STRUCTURE



Many states and cities across the United States have one or a few organizations that may be considered an ACO, but health care in California can be conceptualized as an 'ACO ecosystem'. In 2009, California had 285 physician organizations, both integrated medical groups and Independent Practice Associations (IPAs), which have many of the characteristics described in the current national policy debate. These include primary and specialty care physicians who care for defined populations of patients, provide or arrange for hospital services, and publicly report data on their clinical and financial performance. California's provider organizations vary in their conformity with the parameters discussed in the national debate, but many go beyond the minimum set of ACO activities to include preventive care, chronic care management, and complex case management, often supported by clinical information technology and financed through partial or global capitation payment. For purposes of this paper, these California provider organizations will be referred to as ACOs.

ACOs in California care for 15.7 million prepaid enrollees covered by commercial HMO, Medicare Advantage, Healthy Families and Medicaid managed care, plus numerous Medicare fee-for-service and commercial PPO enrollees. In this state, approximately 56% of individuals with commercial insurance, 45% of Medicare beneficiaries, and 52% of Medicaid beneficiaries receive their care from an ACO (see Table One); collectively these account for 54% of all persons with health insurance in the state. (It is not possible to quantify how many non-HMO patients obtain their health care from ACOs.) California's provider organizations span a wide spectrum of sizes and structures, from the fully integrated Kaiser Permanente with 6.7 million enrollees to small medical groups and IPAs, some with fewer than 5,000 patients.

TABLE 1

ACO HMO Enrollment as a Percent of Total Insured Californians, 2008				
Insurance Type	All Types (Total Enrollees)	Commercial	Medi-Cal / Healthy Families	Medicare
ACO HMO Enrollment	15,943,850	11,285,950 (71%)	3,164,000 (20%)	1,493,900 (9%)
Entire Insured Population	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.

The essence of the ACO concept is that the structure, size, and organizational relationships of provider practices influence their clinical and financial performance. While most American physicians continue to practice in solo or small group settings, the California experience is one of physicians coming together into entities that have stronger clinical, financial, information technology, and managerial capabilities than the traditional cottage industry. The California experience includes both successful and unsuccessful examples of each type of ACO, and no one size, structure, or hospital relationship appears to dominate the others. The fact that there is no single best model to emulate complicates the national debate, but it also allows each local community to find the ACO model that best fits their environment and culture.

In 2009, California had 285 physician organizations, both integrated medical groups and Independent Practice Associations (IPAs), which have many of the characteristics described in the current national policy debate.

TABLE 2

Distribution of HMO Enrollees by Type of ACO, 2009					
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%)

1. 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 Health 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.

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

3. The 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/>).

Integrated Medical Groups: California has 133 integrated medical groups with employed primary care and specialty physicians, including those owned by their member physicians, those owned directly or indirectly by hospitals, and those built around community clinics and other safety net organizations. Most prominent are the two groups affiliated with Kaiser Permanente, which have 10,600 physicians serving 6.7 million enrollees across the state. Other prominent integrated medical groups include the Palo Alto Medical Foundation, HealthCare Partners Medical Group, Scripps Clinic, Sharp Rees-Stealy Medical Group, Sansum Santa Barbara Medical Foundation, and Facey Medical Group. Collectively (excluding Permanente Medical Groups), the integrated medical groups serve 4.4 million prepaid Medicare Advantage, Medicaid managed care (called Medi-Cal in California), and commercial HMO enrollees, plus additional commercial PPO and Medicare fee-for-service patients. Due to the low payment rates offered by Medicaid and to the difficulty of providing a single standard of care to commercially insured and Medicaid patients where per-patient revenues are so different, Medicaid and commercial enrollment in integrated groups is often segregated between providers who see a high proportion of either Medicaid or commercial patients. 67% of Medicaid patients served by integrated medical groups are in groups with between 80% and 100% Medicaid enrollees; conversely, 92% of integrated group commercial enrollees are in groups with between 0% and 20% Medicaid enrollment.

LESSON ONE:

A variety of organizational structures are effective at delivering high quality coordinated care; at least as important to success as structure are an organization's capabilities, culture, and infrastructure, as well as the alignment of goals between the organization and its individual physicians.”

Independent Practice Associations: The majority of ACOs in California follow the IPA model, in which the ACO serves as an umbrella organization for solo physician practices and for small to midsized groups. IPAs are sometimes referred to as ‘network model medical groups’ to highlight the fact that they perform most of the same functions as integrated (‘staff model’) medical groups. There are 152 IPAs in California, serving 4.8 million HMO enrollees. The IPA performs many of the same functions as the integrated medical group: contracting with HMOs for capitation payment, paying individual physicians on a fee-for-service or sub-capitation basis, providing information technology and other capabilities and services to the small practices, and sponsoring preventive and chronic care management programs. Prominent examples include Hill Physicians Medical Group, Monarch HealthCare, Brown and Toland Medical Group, Heritage Provider Network, Primecare, Sante Community Physicians, and Sharp Community Medical Group. Some provider organizations in California include both integrated medical group and IPA components, as they find their core managerial and clinical programs can be applied to these different settings. It is difficult to obtain data on the number of the patients who are in the integrated group versus IPA; some of the entities listed above as integrated medical groups have IPA ‘wrap-around’ components, while some listed as IPAs have integrated groups underneath their contractual umbrellas.

The California experience does not indicate that the structure of the physician organization exerts a decisive impact on its financial or clinical performance. Hence, while efficiency and quality are likely improved when physicians cooperate with one another through an organizational structure, the specific form taken by that structure is not of primary importance. Many observers hypothesize that integrated medical groups perform better than more loosely structured IPAs, and further research may

identify distinguishing aspects of behavior. It may be that the best medical groups outperform the best IPAs, but there are sufficient numbers of high-performing IPAs and low-performing integrated medical groups that the available research finds no consistent association between structure and performance.^{i, ii, iii} The ultimate indicators of organizational success are market share and profitability, and here there is also no trend either in favor of or against integrated groups relative to IPAs. These indicators, as well as the salience of composite ACOs that combine integrated group and IPA components, highlight the durability and compatibility of both models.

WHAT MATTERS FOR ACO PERFORMANCE? CAPABILITIES, CULTURE, AND INFRASTRUCTURE

While structure is not the defining element of an organization's performance, there is evidence that internal attributes and capabilities play a pivotal role in the delivery of high-quality patient care. These attributes include the presence of a robust organizational culture, with strong leadership, clear, shared vision and goals, data sharing to help providers reach these goals, and feedback and accountability for individual providers. These help to ensure that the goals of the organization are aligned with the goals of the individual physicians, which is paramount to high performance. Also important are participation in external quality improvement incentive programs^{iv} the use of coordinated care teams and adherence to evidence-based guidelines,^v recommended care management processes for treating chronic illness,^{vi} and a robust health information technology infrastructure.^{vii} Finally, critical to the success of an ACO is the strength of its administration and non-physician staff. Physicians alone cannot make ACOs work; there must also be investments in intellectual capital to ensure that an organization's systems are highly-functioning. Developing the capabilities and infrastructure needed for high performance can be challenging, but it will be necessary if ACOs are to meaningfully take clinical and fiscal responsibility for large populations of patients.

Physicians alone cannot make ACOs work; there must also be investments in intellectual capital to ensure that an organization's systems are highly functioning.

SIZE: ECONOMIES AND DISECONOMIES OF SCALE

The size of ACOs in California is most frequently measured in terms of HMO enrollment, a metric that is applicable to IPAs as well as to integrated medical groups, but that does not measure services provided to PPO, Medicare fee-for-service, and other non-prepaid patients. ACOs range in size, as can be seen in Table Three; some are very large, but the vast majority of entities (223, or 78%) serve fewer than 50,000 prepaid patients.

The largest ACOs benefit from modest economies of scale when investing in patient registries, electronic medical records and supporting clinical programs. However, they may also suffer from diseconomies of scale that can afflict large practices, in terms of loss of culture and sense of ownership by individual physicians. On top of this, the empirical evidence does not support the claim that larger medical groups have meaningfully better chronic care programs or clinical performance as measured in the state's pay for performance program.^{viii, ix, x} Small ACOs have persisted, despite the absence of scale economies. Some small ACOs

TABLE 3

The Distribution of HMO Enrollment in California's ACOs, 2009				
Total Enrollment Range	Number of Groups	Percent of Total Groups	Number of HMO Enrollees	Percent of Total Enrollment
< 5,000	73	26%	154,650	1%
5,000 – 9,999	40	14%	301,250	2%
10,000 – 14,999	35	12%	444,200	3%
15,000 – 24,999	44	15%	844,750	5%
25,000 – 49,999	31	11%	1,100,750	7%
50,000 – 99,999	38	13%	2,531,500	16%
> 100,000	24	8%	10,341,250	66%
Total	285	100%	15,718,350	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.

are able to succeed because they use outside management services organizations and hence benefit from larger scale in information technology, contract negotiation, and other administrative functions. These findings are important for the national ACO debate, because they suggest that it is not necessary to reach very large scale in order to achieve high organizational performance, and most regions of the nation lack the population density to support multiple large ACOs.

An issue closely related to size is expansion, and the California experience is clear with respect to the difficulty of efforts to expand ACOs across regions, or rapidly through mergers and acquisitions. Most efforts to aggregate medical groups across regions have been unsuccessful, reflecting the truism that health care is local. However, several ACOs cover broad geographic areas within the southern California (e.g., Heritage, HealthCare Partners) or northern California (e.g., Hill Physicians) regions, and Kaiser Permanente has a strong presence in all urban regions of the state, although even Kaiser faced difficulties expanding outside of its core geographic markets, and now focuses on expansion into proximate markets.

California's experience has also been that rapid expansion through mergers and acquisitions can cause market instability. During the 1990s, it was believed that there were economies of scale even at very large sizes and that the capabilities of existing ACOs could easily be extended to newly incorporated practices and medical groups. Investment capital flooded into the market, both from Wall Street (physician practice management firms) and from hospitals (integrated delivery systems), and there ensued a bidding war to acquire practices and expand regionally and nationally. These experiences were largely negative, and led to the closure or bankruptcy of 147 physician organizations serving 4.1 million patients in California between 1998 and 2002. Despite these experiences, the ACOs that survived have thrived, and California's healthcare marketplace has maintained stability throughout the past decade.

ORGANIZATIONAL RELATIONSHIPS WITH HOSPITALS

Relationships between Californian physician organizations and hospitals take a number of forms, ranging from exclusivity to fully independent, as outlined in the text box below. The national ACO debate envisages a central role for hospitals, as there are considerable efficiencies to be gained through coordination of care across the continuum and the reduced need for hospital services, which are the highest cost element of the delivery system. Hospitals can also serve as an important locus for investments in management expertise, information technology, and physical facilities, investments that can be difficult for independent physicians, especially in rural areas with few providers.

Medical Group-Hospital Relationships: The California Experience

Some of the most prominent physician organizations in California are linked to hospitals through integrated delivery systems, including the Sharp Rees-Stealy Medical Group in San Diego, which accepts global capitation for commercial and Medicare enrollees, and, most prominently, the Permanente Medical Groups, which are linked to both the 27 Kaiser Foundation hospitals across the state and the Kaiser Foundation Health Plan. Other hospital-physician organization relationships take the form of joint ventures, foundation models, and partnerships, although the majority of California's physician organizations do not have exclusive relationships with hospitals.

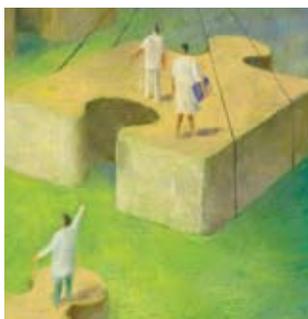
Realization that stronger alignment between hospitals and physicians is beneficial for both parties has led some Californian hospitals to seek stronger alignment with physicians,^{xi} although this trend might have the undesirable consequence of consolidating market power and driving up health care costs in a market. This has happened to some degree in Northern California, where a single delivery system that includes both hospitals and physician groups commands roughly one-third of the non-Kaiser healthcare market.

Currently, there is also some experimentation with new hospital-provider relationships that focus on both greater integration and cost control. Although it is too early to comment on its effectiveness, there is presently an ACO pilot program in the Sacramento region that is being undertaken by Hill Physicians Medical Group, the California Public Employees' Retirement System (CalPERS), Blue Shield of California, and Catholic Healthcare West, a hospital system. The hospital, physician group, and health plan partners have formed a virtual integrated model and agreed to keep CalPERS costs at or below what they were in 2009 in the Sacramento area. All participants—the physician group, the hospital, and the health plan—will have to work together to ensure that the pilot is a success.

LESSON TWO:

In California, a range of relationships exist between physician organizations and hospitals. Alignment of incentives between physician organizations and hospitals offer important opportunities for performance improvements across the entire continuum of care.

PAYMENT METHODS



LESSON THREE:

As a method of payment, capitation can be effective at encouraging coordinated care, but payment methods should vary across ACOs depending on an organization's ability to assume risk.

A key differentiator of the California experience is the prevalence of capitation as a payment method, whereas other geographies use mostly fee-for-service even for large multispecialty medical groups. The content and reach of capitation has varied over time, and currently varies considerably across organizations within the state. Most California ACOs receive capitation payment for physician services, but some are paid on a prospective basis for hospital services, as well. Most also receive some incentives payments linked to effective management of hospital services.

A key challenge facing ACOs in California has been the narrowing scope of capitation payments, which now most frequently cover only physician services to the exclusion of hospital and pharmacy services. Most medical groups (and hospitals) retreated from global capitation, which weakened the incentives for ACOs to manage the most expensive components of health care. This, in turn, reduced the once-important cost advantage of the ACOs and their partner HMOs relative to the cottage industry of small physician practices and PPO insurance products. Professional services capitation nevertheless gives much stronger care management incentives than would the shared savings programs currently highlighted in the national ACO discussion. Capitation creates downside risk as well as upside opportunity for providers, whereas shared savings programs offer only upside opportunity. Shared risk programs are necessarily of limited scale (in terms of the potential size of the performance-based bonus) unless providers are willing to accept significant upfront reductions in the base fee-for-service payments, which they are typically unwilling to do. Limited payment incentives such as shared savings leave health plans in the primary position with respect to managing the costs of care, which inevitably creates strains over third party intervention in the physician-patient relationship. While it is necessary to start with small changes to existing payment methods so as not to create turbulence and backlash, incremental changes in payment methods will likely cause only incremental changes in physician behavior, and hence in progress towards quality and efficiency goals.

SCOPE OF CAPITATION

An important issue in capitation is the scope of services covered, as this determines both the risks and potential rewards from prospective payment. Almost all ACOs in California receive capitation payments that cover primary care, and most are also paid capitation for specialty care physician services (the combination of primary and specialty services is termed 'professional services capitation'). Indeed, this prospective payment for physician services, accompanied by authority for the review and management of referrals and procedures, defines the 'delegated model' in California. Important services that often fall outside the scope of capitation include:

- ▶ **Hospital services:** Financial responsibility for managing hospital services is central for managing costs, especially for Medicare patients, but California ACOs have largely exited global capitation. In some cases, this is due to unwillingness by the local hospital to participate, while in others the physician organization itself

prefers not to accept prospective payment for these more costly and complex services. Most hospital systems have found that they can obtain higher revenues from fee-for-service (typically, per diem rates plus additional payments for high-cost medical devices, supported by stop-loss criteria at which point payment reverts completely to fee-for-service). Global capitation still exists for patients in some markets (e.g., LA County, San Diego), but is now less common for commercially insured HMO patients. Most ACOs have the potential to gain some additional revenues if they manage hospital utilization and expenditures for the health plans through various ‘performance-based contracting’ or ‘hospital risk pool’ mechanisms. The Integrated Healthcare Association’s (IHA) pay-for-performance program recently added efficiency into its Appropriate Resource Use measures, and is also working on developing metrics for total cost performance, so that participating medical groups will be awarded quality bonuses based on how well they manage costs.

- ▶ **Pharmacy services:** After substantial initial interest in and experimentation with capitation for prescription drugs, most ACOs in California have dropped pharmacy capitation due to the difficulties in anticipating the pipeline of new product introductions and in managing drug use in the face of direct-to-consumer advertising. Despite this, ACO physicians cooperate with health plans on promoting generic substitution, and in turn receive financial incentives under pay-for-performance programs, which have had some success in controlling costs.
- ▶ **Specialty drugs:** Biopharmaceuticals, vaccines, and other office-administered drugs were historically included in the professional services capitation payment as ancillary to the practice of medicine. However, with the exception of some very large entities, most ACOs have renounced capitation for these products, as it is difficult to manage these complex and costly drugs, and to anticipate what will be coming out of the pipeline.

A critical consideration in the expansion of capitation and its long-term effectiveness in the emerging post-reform environment is the development and application of appropriate risk adjustment algorithms.

A critical consideration in the expansion of capitation and its long-term effectiveness in the emerging post-reform environment is the development and application of appropriate risk adjustment algorithms, so that capitation payment amounts reflect the risk characteristics of the populations for which the ACOs are accountable.

LEVEL OF PAYMENT VERSUS STRUCTURE OF PAYMENT

It is important to distinguish the structure of physician payment (e.g., capitation versus fee-for-service) from the level of physician payment (e.g., high versus low payment rates). Originally, ACOs in California had a price advantage over small fee-for-service practices, as they had lower costs due to effective management of specialty services, hospital admissions, and length of stay, but as that utilization advantage has eroded, the cost advantage shrunk. Also fueling this narrowing cost advantage is the fact that some ACOs have consolidated and gained bargaining leverage, either in collaboration with hospitals or on their own, leading to higher levels of physician payment (and insurer costs) compared to the fragmented cottage industry, which has little bargaining power.

It is very difficult to obtain apples-to-apples comparisons of costs between ACOs and cottage industry physician practices, due to both the differences in

patient populations (adverse selection, insurance benefits, urban versus rural geographic prevalence, and the importance of hospital costs that are not under physician control), and the different levels of consumer cost sharing in HMO versus PPO products. PPOs in California typically impose a deductible and coinsurance, both of which shift a much larger share of overall costs to the enrollee than does the benefit design of the HMO product. HMO products typically impose neither deductible nor coinsurance but, rather, rely on modest dollar copayments for office visits (e.g., \$5-15). It is possible that the HMO would be cheaper than the PPO if it had similar levels of consumer cost sharing, but cost sharing differences are deeply embedded in the regulatory requirements facing the different insurance products. While cost comparisons are difficult, the bottom line is that trends in enrollment, which initially favored the HMO, now favor the PPO (and the cottage industry of small practices).

PAYMENT FOR INDIVIDUAL PHYSICIANS WITHIN THE ACO

It is also important to distinguish between the payment structure used for the physician group and the payment structure used for the individual physician. There is a fundamental tradeoff between rewarding responsibility for the entire course of care, which exposes each individual doctor to the risk of non-performance by others, and rewarding only individual performance and productivity, which offers no compensation for clinical cooperation or efficient use of resources. The virtue of the ACO structure is that it permits hybrid methods, with physicians paid as a group based on collaborative performance (insurer payments to the ACO) and then as individuals based on individual performance (ACO payments to individual physicians). Most ACOs in California are paid capitation for a range of services by HMOs, while the individual physician is paid by the ACO mostly for his or her own contribution, with a bonus based on group and individual performance. In integrated medical groups, physicians are paid a salary, which is based in turn on a mix of individual productivity (patient visits and procedures), citizenship (cooperation with guidelines and other ACO programs), care quality (clinical processes, outcomes, and patient satisfaction), administrative responsibilities, and group profitability. Within IPAs, individual physicians are paid either on a fee-for-service or sub-capitation basis, typically with a bonus based on many of the same metrics as those used by integrated groups.^{xiii}

In principle, bundled episode of care payments for high-cost acute interventions could be paired with capitation for routine and chronic care services, but this would increase the complexity of the payment and incentive structure.

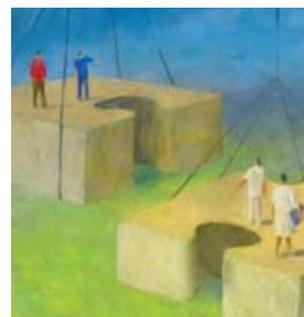
This discussion of payment methods within the California ACO contrasts with conventional distinctions between insurance risk and technical risk (also referred to as 'performance risk'). Some critics of capitation have favored episode payment, where technical risk is borne by the provider while insurance risk of above-average patient severity is borne by the insurer. It is very difficult, however, to distinguish technical from insurance risk in the era of chronic illness. ACOs in California may offer an effective instrument for the management of chronic care, which helps slow the progression of chronic illness, but may not be an especially effective instrument for managing the acute manifestations of chronic illness (which is the natural target of episode payment). In principle, bundled episode of care payment for high-cost acute interventions could be paired with capitation for routine and chronic care services, but this would increase the complexity of the payment and incentive structures.

RELATIONSHIPS WITH HEALTH INSURANCE PLANS

The most successful ACO in California is Kaiser Permanente, where there is an exclusive relationship between the insurer and its medical groups and, in most regions, with its own hospitals. Some thought leaders consider vertical integration with an insurance provider to be core to the success of this ACO, since cost reductions achieved by the Permanente Medical Group are directly reflected in lower premiums to the insurer (the Kaiser Foundation Health Plan), in turn attracting more enrollees. The contemporary policy debate over ACOs assumes, however, that the provider organizations will not be vertically integrated with insurers in this manner, neither in traditional Medicare nor in commercial health insurance plans. This creates a potential dilemma, as in a pluralistic organizational context where most insurers contract with most ACOs, improvements in efficiency by one ACO will not greatly affect the cost profile of any one health insurance plan, and hence will not immediately attract new enrollees and patients to the high-performing medical group.

Kaiser Permanente emerged during a period when most health insurers were not interested in prepaid group practice, so it developed its own insurance vehicle that marketed the services of the medical group to employers and prospective members. At the time, this group model HMO structure was considered radically distinct from traditional health insurance and was seen as offering significant quality improvements and efficiencies, somewhat similarly to the contemporary debate over the quality and efficiency-promoting potential of ACOs. Most of the non-Permanente medical groups in California emerged in response to the challenge posed by Kaiser, and in collaboration with network HMOs such as Maxicare, HealthNet, and Pacificare. These latter health plans originally sought to base their networks on integrated group practices, but quickly realized a need to foster IPAs that could expand their geographic reach. In the early days of physician group formation in California, health plans contracted similarly in terms of their capitation arrangements, which reduced the administrative burden on the groups and allowed them to focus on care delivery. Health plans have also acted in concert with their performance measurement activities, which is discussed in the text box below.

Over time, the insurers came to add PPO products that were not based on ACOs, due to consumer and purchaser interest in even broader network choice. As many insurers converted to for-profit ownership, expanded outside California, and were acquired by larger plans, many of the original ACO-focused health plans found their PPO products had become a larger part of their book of business than their HMO products. Most ACOs in California were not able to diversify into serving PPO enrollees, leading to an asymmetric relationship in which the ACOs remained reliant on the HMO products of national, PPO-focused health plans that no longer were reliant on the ACOs.



LESSON FOUR:

Health plans acting in concert on payment methods and performance measurement helped facilitate the growth of California's provider organizations, and should also play an integral part in fostering ACO development nationally.

A core component of accountable care organization development is the ability to measure and report on performance, a process with which California has a wealth of experience. The California Pay for Performance (P4P) Program is the largest non-governmental P4P program in the US, and the longest-running example of data aggregation and standardized reporting across multiple health plans. Seven health plans participate in incentive payments and public reporting (Aetna, Anthem Blue Cross, Blue Shield of California, CIGNA, Health Net, United-Healthcare, and Western Health Advantage), and an eighth—Kaiser Permanente—participates for public reporting purposes only. The program covers 221 medical groups, representing approximately 35,000 physicians that provide care to over 10 million commercial HMO enrollees. Medicare Advantage and Medicaid managed care patients, while often treated by the same medical groups that participate in the P4P program, are not included (but are covered by different initiatives sponsored by CMS and the state of California). The program is managed by the Integrated Healthcare Association, a statewide healthcare stakeholder group that has acted as a neutral convener and facilitator for physician organizations, health plans, and other healthcare stakeholders.

The goal of the program is to incentivize performance improvements in clinical quality, efficiency, and patient experience through a common measure set, a public report card (published by the California Office of the Patient Advocate), and incentive pay-

Key Points:

- The creation of a single performance-based measurement set and public report card is key in securing the buy-in of physician organizations
- Data aggregation across multiple payers greatly enhances measurement reliability and the trust of the physicians being measured
- Physician groups actively engage in quality improvement, and give the program an average rating of 4 out of 5 when asked about its importance to their organization
- The P4P program has helped create an environment of collaboration between health plans and physician organizations

ments. These payments, made by health insurance plans to physician groups, totaled \$52 million in 2009.

A primary component of P4P is a comprehensive set of measures that helps drive performance improvement; the measurement set is designed to include evidence-based process and outcomes measures in five domains, and has grown in both size and sophistication since the program's inception. The evolution of the P4P measurement set is detailed in the table to the right. The common measure set, data aggregation across plans, and single public report card have been key in securing and maintaining physician buy-in to the program. In an independent evaluation of the program, physician organization representatives rated the program an average of 4 out of 5 when asked about its importance to their organization. ^{xiii}

ACO CONSOLIDATION AND PRICING LEVERAGE

Outside of the context of vertical integration with health plans, the ACO incentive is to demand that payment rates be as high as possible, as the cost of these payment rates are spread across the entire health plan premium and do not differentially affect the premiums faced by the ACO's own patients. Each ACO faces inelastic consumer demand because the premium contribution and the cost sharing required of the patient do not strongly reflect the costs incurred by the patient's ACO, as distinct from the costs incurred by other providers.

Measurement Set Evolution, 2003-2009

Measurements	2003	2008	2009
Clinical – Preventive	8	11	13
Clinical – Chronic	3	6	6
Clinical – Acute	0	4	4
Patient Experience	6	9	9
Information Technology	8	11	11
Systemness	0	8	8
Coordinated Diabetes Care	0	10	11
Efficiency/Resource Use	0	1	6
Total	25	60	68

The Clinical Quality domain measures preventive care and the treatment of acute and chronic conditions using both process and outcomes measures. Standardized national measures are used wherever possible, drawn largely from HEDIS measures. The Patient Experience domain measures patient ratings of the care received by physicians within an organization using the California Patient Assessment Survey in conjunction with the national CAHPS survey.

The IT-Enabled Systemness domain gauges the extent to which organizations provide support and infrastructure to their physicians for systematic care processes that impact all of their patients, such as population management (e.g. registry) and point-of-care (e.g. pharmaceutical prescribing) activities, as well as access and communications standards and individual physician-level measurement and incentives. The fourth domain, Coordinated Diabetes

Care, is designed to promote process redesign and a systematic approach to diabetes care; measures include process and outcomes clinical measures, population management activities, and care management processes.

The final domain, Efficiency, was created in response to rising health care costs and insurance premium increases, and provides measures of cost and resource use. The development of robust efficiency measures to evaluate appropriate resource use, overuse, and cost-efficiency was a challenge for the P4P program, but incorporating these measures was seen as essential by health plan and purchaser stakeholders in order to encourage more cost-conscious care.

Since program inception, participating physician organizations have improved in all measurement areas. Although patient experience gains have been modest, clinical performance has shown steady, incremental improvement. There have been substantial gains in the adoption of clinical information technology, with more than two-thirds of participating organizations demonstrating some IT capacity. Adoption of clinical information technology is encouraging, as analysis of performance data has revealed a correlation between IT capabilities and clinical performance.

California's P4P program has helped engender collaboration between physician organizations and their health plan payers, and has created a strong foundation for performance measurement. As such, its evolution holds important lessons for the development and implementation of ACO performance measures.

Some ACOs recognize this dilemma and highlight the importance of 'affordability', but they face a difficult collective action problem. A decision by any one of them to moderate its negotiated rates with the health insurance plans would not have a measurable effect on the premium, yet would weaken that ACO financially and undermine its ability to invest in clinical capabilities, physical facilities, electronic health records, and acquisitions of other medical groups. The only way to counteract this tendency would be for the consumer's copayment or premium contribution to vary according to choice of ACO. Some prominent hospitals and ACOs in California have negotiated

LESSON FIVE:

ACOs are not a panacea for health care spending control.

clauses with the health plans precisely to prevent this. There must be an economic incentive for lower costs and provider prices, lest the consolidation of providers into larger organizations not merely create a context for further rate increases to insurers and premium increases to purchasers and consumers.

PRODUCT DIVERSIFICATION INTO SERVING PPO PRODUCTS

A salient characteristic of ACOs in California is that they have been largely unsuccessful in attracting PPO patients; indeed, some consider the PPOs to be their competitor and the HMOs to be their partners and marketing agents. This has proven a major liability, as enrollment has shifted to PPOs due to lighter regulation and more flexible benefit design, on the one hand, and to the shift by many national employers from multiple local HMO plans to a single national PPO insurer, on the other. Most IPAs in California do not participate in fee-for-service contracting with PPOs to any significant extent, partly due to anti-trust limits and partly due to the desire by large PPOs to retain a direct contractual relationship with individual physician practices (rather than only indirectly, by contracting with IPAs that subcontract with individual practices). For IPAs, it is difficult for clinical and administrative infrastructure (e.g., care management programs and electronic health records) to be financed using fee-for-service, where payments go directly to the individual physician practice rather than via the IPA. Although many of the individual physician members of IPAs treat PPO (and Medicare fee-for-service) members in their practices, the care for these patients is neither measured nor managed by the IPA. For integrated medical groups, there is less of an obstacle to financing infrastructure from fee-for-service, and some of these ACOs contract on a fee-for-service basis with commercial PPO plans and accept Medicare fee-for-service. However, most of the major medical groups in California are focused on the commercial HMO, Medicare Advantage, and Medicaid managed care plans that pay on a capitation basis, rather than on commercial PPO, traditional Medicare, and traditional Medicaid that pay on a fee-for-service basis.

ACOs have been challenged by the national and statewide enrollment trends away from HMO products. While many ACO leaders say their model requires investment in organizational capabilities and increased use of primary care services to restrain the use of specialty and hospital services, high deductibles penalize primary care and are permissive to the above-deductible specialty and hospital services. There have been efforts to facilitate deductible-based HMO products in California that could rely on existing ACOs for their provider networks, but these have not flourished. The greatest challenge and greatest opportunity facing ACOs in California and elsewhere is the potential for integrating the coordinated care programs developed originally for HMO and other narrow network insurance products into PPO and other broad network products.

ACO INVOLVEMENT IN MEDICARE AND MEDICAID

ACOs in California play a major role as network providers in Medicare Advantage and, conversely, Medicare Advantage plans have provided a significant fraction of

LESSON SIX:

ACOs must be agnostic to insurance type; most provider organizations in California have focused on commercial, Medicare, and Medicaid HMO plans for their patients, but for ACOs to be viable across the country, mechanisms must be found to encourage PPO and traditional Medicare and Medicaid patients to use their services.

the revenues and enrollment that sustain the ACOs. Owing to this, these organizations have lobbied for the maintenance of high Medicare Advantage payment levels. They have not attracted large numbers of Medicare fee-for-service patients and, generally, have tended to view the fee-for-service program as a competitor rather than as a partner. New directions for the traditional fee-for-service Medicare program are central to the contemporary policy debate, which seeks to expand the role of ACOs in traditional Medicare, and ACOs in California are seeking ways to participate more strongly in the traditional Medicare program (ideally under new payment methods).

Medicaid managed care plans in California rely heavily on IPAs to structure their physician networks, with 53% of Medicaid HMO enrollees that seek care from California’s ACOs treated by IPA providers. These IPAs typically see few commercially-insured patients, and IPAs that serve commercial enrollees generally have small or non-existent Medicaid populations. The Medicaid-focused IPAs operate on a much lower administrative and organizational cost structure than do those serving the Medicare and commercially insured populations. Some of the integrated medical groups serve Medicaid managed care, but many do not. This bifurcation is due to the very low payment rates offered by the Medicaid managed care plans, relative to the rates paid by Medicare Advantage and commercial insurance plans. Table Four showcases the concentration of Medicaid enrollees in ACOs by the percentage of Medicaid enrollment. The role of ACOs within Medicaid managed care networks is an important issue, given the Medicaid enrollment expansions expected under health reform; forging a new relationship between ACOs and Medicaid is important both to ACOs for patient volume, and to Medicaid because it suffers from inadequate provider participation.

TABLE 4

The Distribution of Medi-Cal and Healthy Families HMO Enrollment in California’s ACO by Percent of Enrollment, 2009

Medi-Cal / Healthy Families Enrollees as a % of Group Enrollment	Number of Groups	Percent of Total Groups	Number of Medi-Cal / Healthy Families HMO Enrollees	Percent of Medi-Cal / Healthy Families HMO Enrollment
0%	77	27%	0	0%
>0 – 9.9%	51	18%	394,700	11%
10 – 24.9%	12	4%	131,600	4%
25 – 49.9%	18	6%	90,950	3%
50 – 79.9%	22	8%	546,000	16%
80 – 99.9%	55	19%	1,584,400	46%
100%	50	18%	699,500	20%
Total	285	100%	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.

CONSUMER CHOICE



The US health policy framework emphasizes the importance of free consumer choice of provider. There are two distinct conceptualizations of consumer choice, however, and the ACOs in California focus on one while the majority of health plans and purchasers nationally focus on the other. The first concept of consumer choice is that of ‘managed competition’, in which consumers choose among health plans that offer distinct provider networks (ACOs), and where the individual enrollee is required to use personal funds to ‘buy up’ to high-priced plans (that use high-priced or less efficient provider networks). Cost conscious choice happens primarily at the time of selecting a health plan and, as part of that process, of selecting an ACO. The second concept of consumer choice is that of ‘consumer driven health care’, in which consumers enroll in a broad-network PPO product and choose among individual physicians and hospitals at the time of care, with the requirement to personally pay a substantial portion of the provider fees through coinsurance and deductible provisions. In this second framework, consumers do not need to select a provider organization that coordinates the majority of their care; rather, they can choose and change individual physicians without regard to those physicians’ relationships with one another.

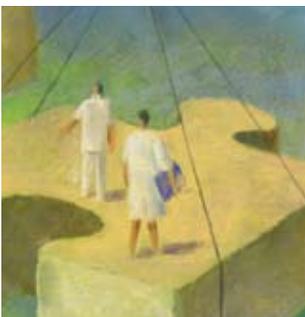
LESSON SEVEN:

Balancing patient choice with the desire to decrease costs and effectively coordinate care is difficult.

California’s experience underscores the challenge of promoting care coordination in an environment of unrestricted provider choice.

ACOs in California continue to derive the vast majority of their patients and revenues from HMO products, despite the eroding reputation and market share of those products nationally. This is testimony to the difficulty in pursuing coordinated care in a choice context where the patient can change providers at any time, and in applying capitation or shared savings incentives to provider teams when they are not fully responsible for the patient’s care and costs. A significant challenge facing ACOs in California is modifying their structures, practices, and relationships with health plans so that they can effectively coordinate patient care in a broad network environment. Conversely, a significant challenge facing ACOs outside California is how to achieve the goals of coordinated care and performance improvement when consumers can go outside the ACO for care at any time. Both of these challenges are difficult and, indeed, the national ACO policy debate has not seriously grappled with how to balance the competing virtues of choice and coordination.

PUBLIC POLICY AND REGULATION



Many aspects of the policy and regulatory environment in California have been favorable to ACOs, compared to the political culture in states that have sought to protect the cottage industry against the incursion of managed care. The supportive aspects of California’s policy framework have been due to the historically strong presence of Kaiser Permanente, as well as the embrace of managed care principles by prominent public purchasers such as CalPERS and private purchasers such as the Pacific Business Group on Health (PBGH). The California Department of Managed Health Care (DMHC) supports the prepaid medical group model and is skeptical of

high-deductible health plans and PPO products that shift substantial financial risk onto consumers. That skepticism has resulted in some restrictions on managed care products that hamper their ability to compete effectively against PPO products, which can be offered at lower prices because of more limited benefits.

For many years California experienced a growth cycle of innovative ACOs, enhanced appreciation by policymakers and purchasers who recognized their potential for improved efficiency, and consequent further enrollment growth. In the most recent years, however, this cycle appears to have reversed itself, as regulation has come to disadvantage HMOs relative to PPOs, and as many employers have shifted their contracts to PPOs that do not use ACO providers. The key dimensions of public policy and regulation for the ACO ecosystem include oversight of financial solvency, consumer protections around access and quality, and anti-trust oversight of non-competitive practices.

REGULATION OF FINANCIAL SOLVENCY

Any business entity paid on a prospective basis is exposed to the financial risk that its expenses will exceed its revenues. Because ACOs in California are paid on a capitation basis, they are subject to the insurance risk that they may attract a mix of patients more ill than anticipated, as well as the business risk that they may not be able to contain costs below revenues even if paid on an actuarially sound basis. In the 1990s, many physician organizations sought to accelerate their growth by taking on large numbers of new patients without careful evaluation of the underlying insurance and business risks. The ensuing bankruptcies caused major disruption for patients and providers, and stimulated the California state government to extend some of the regulatory requirements and oversight historically focused on the insurance industry to ACOs. It appears that the state legislation and its enforcement entity, the DMHC, have been able to foster organizational probity through financial and disclosure mandates, as in the subsequent decade, there have been fewer medical group bankruptcies. However, it is unclear whether this regulation has contributed to the loss of ACO market share.

Provider groups accepting capitation must submit quarterly reports to DMHC that include financial surveys, statements of what percent of completed claims they have reimbursed, contested, or denied within 45 days, and whether or not they calculate and document incurred but not reported (IBNR) claims. DMHC uses these to assess whether or not a group has maintained positive working capital and tangible net equity, developed adequate mechanisms to calculate and provide for incurred claims from outside providers whose services must be paid from the ACO's capitation revenues, and promptly pays or adjudicates such claims with 45 days of receipt. Health plans must meet similar requirements, and are subject to similar financial examination.

In addition to the financial requirements for ACOs paid on a capitation basis, California developed a licensing and regulatory structure for provider organizations that are large and sophisticated enough to accept global capitation. However, this licensing category has proven to be of only modest market importance. During

LESSON EIGHT:

Regulation of the financial solvency of provider organizations is important to ensure market stability.

the 1990s, some prominent medical groups and hospitals launched their own fully insured HMOs, but most of these entities were not able to compete successfully against mainstream health plans and were sold or disbanded. Today, the number of entities licensed to accept global capitation is quite small, and accounts for a minority of HMO enrollees in the state.

CONSUMER PROTECTION

The ACO policy debate emphasizes the importance of collecting and disseminating to consumers measures of cost and quality of performance.

During the late 1990s, managed care came to be viewed as a financing mechanism that had the potential to adversely influence quality and access. As the consequent provider and consumer backlash grew, the number and type of mandates introduced under the rubric of consumer protection grew commensurately. California was not exempt from this national trend, and witnessed a significant increase in the number and type of regulatory mandates for HMOs and the ACOs with which they contract. Some regulatory mandates in California affect all forms of insurance and delivery, but most are restricted to HMOs and to ACO-based providers. This asymmetry and the different regulatory demands it creates have driven concerns among ACO leaders that self-insured corporate health benefits programs and high-deductible health plans, which largely avoid ACO providers, benefit from weaker regulatory requirements (and that their enrollees face substantially higher risks) than do the HMOs and their ACO-based delivery systems. This dynamic is unique to California, as it is the only state with a stand-alone HMO regulator.

The ACO policy debate emphasizes the importance of collecting and disseminating to consumers measures of cost and quality of performance. Presumably, this reporting will limit any incentive for an ACO to reduce access or quality in the pursuit of cost control. However, it is unclear whether performance reporting is sufficient to protect consumers, or whether direct mandates of network access, independent medical review, and other consumer protections need to be extended from health insurance plans down the level of the ACO, as has happened in California.

Mandated insurance benefits: California attempted to embrace the managed care vision of standardized, comprehensive insurance benefits while placing the indemnity or ‘consumer-driven’ vision of product designs with substantial consumer cost sharing under a different regulatory structure. DMHC vigorously enforces benefit mandates for the health plans (mostly HMOs) under its purview, whereas the regulatory authority of the California Department of Insurance (CDI) authorizes less rigorous oversight for the high-deductible PPO products under its purview. Some providers and thought leaders in California chafe at what they perceive to be excessive ACO regulation by DMHC, and argue that all health insurance types should be subject to the same oversight. In particular, they argue that PPO products should be subject to the same mandates concerning benefits, access, and quality reporting, and that disparate regulation likely has been one factor leading to the decline in market share of products that rely on ACOs. In principle, strict and uniform regulation benefit design would be advantageous to ACOs, since these entities place their cost control emphasis on provider payment incentives rather than on cost sharing requirements for consumers.

Independent medical review (IMR): The IMR process is an opportunity for patients to obtain external review of decisions made by managed care organizations under the DMHC (as well as for Medi-Cal managed care plans). For other forms of insurance, CDI also has an IMR process, although patients covered by Medicare (including Medicare Advantage), Medicaid fee-for-service, and worker’s compensation are ineligible for either the DMHC or CDI programs. IMRs are used for coverage denials of requested treatments that are considered experimental or investigational, disputes over the medical necessity of a service, and denied claims for reimbursement for medically necessary emergency or urgent care services. The IMR process only covers services that are covered in the enrollee’s insurance contract, and the enrollee must first have gone through his or her health plan’s internal grievance system.

Network breadth and access: Each health plan in California that is regulated by the DMHC (which excludes self-insured plans, high-deductible PPOs, and traditional indemnity) must ensure that its network is large and varied enough for patients to gain access to care “within a time period appropriate for their condition.” Additional requirements include quality assurance standards that require enrollees be offered appointments within reasonable time standards. Within each area that an insurer offers a plan, basic health services and specialized care “shall be readily available and accessible” to all enrollees; there are requirements that primary care facilities shall be within “reasonable proximity” to the businesses or personal residences of enrollees, that there should be “reasonable” hours of operations, and that emergency health care shall be available around the clock. The extensive network access regulations imposed on HMOs (and thereby on ACOs) by the DMHC further disadvantage those entities compared to PPO products and their providers, who face no comparable regulations.

These requirements for HMO products have helped to ensure that capitated providers do not deny care to enrollees, and that patients have sufficient access to health care services and providers. Together with the financial solvency requirements for providers, these protections constitute some of the most robust health care consumer protections in the country.

ANTI-TRUST POLICY

Federal anti-trust policy has traditionally been skeptical of large provider organizations, seeing them as a potential locus for anti-competitive price increases. The Federal Trade Commission (FTC) has fought hospital mergers and efforts by IPAs to bargain on a fee-for-service basis with health plans. Federal regulators interpret prepaid group practice, including capitated IPAs, as pro-competitive rather than anti-competitive, however, since these entities accept financial risk for the cost of care and hence have the incentive to reduce costs to attract more patients. However, in recent years, concern has grown that hospitals are acquiring physician practices and medical groups with the intent of presenting a united front to insurers and demanding payment increases from both HMO and PPO products.

California has been the subject of substantial hospital and physician consolidation, and has been presented as a case study of how integrated care can lead to higher

LESSON NINE:

Consumer protections from capitated provider organizations need to be balanced, not overburdening.

rather than lower costs under some circumstances. A recent paper by Berenson and colleagues^{xiv} argues that the relative success of physicians in California in forming large provider organizations, with or without ownership linkage to hospitals, has fueled the acceleration of cost inflation over the past decade. Some observers claim that ACO growth has contributed to the erosion of the once-substantial cost advantage of the HMO product compared to the PPO product, in turn contributing to the erosion of HMO market share. There are other important reasons underlying enrollment growth in the PPO, including lower premiums due to higher consumer cost sharing and fewer regulatory requirements in terms of network access and performance reporting. Nevertheless, it would be ironic if the growth of ACOs proved to be a self-limiting process due to its effect on bargaining power, premium prices, and enrollment in the commercially insured sector.

The movement to promote ACOs needs to be reconciled with policy efforts to reduce consolidation and pricing power on the part of hospitals and physician practices. This will be particularly important for ACOs that are paid on a fee-for-service basis, which is precisely the context where the FTC has viewed integration as anti-competitive and cost-increasing. This policy issue will become salient for ACOs in California to the extent that they begin to grow enrollment in traditional Medicare on a fee-for-service basis, and seek to extend this involvement into contracting with commercial PPO plans. While traditional Medicare and commercial PPOs are similar in paying physicians on a fee-for-service basis, they differ importantly in that Medicare imposes a non-negotiated, formula-based payment level (fee schedule), whereas commercial PPOs must negotiate fee schedules with providers. The consolidation of physicians and hospitals in local markets can significantly raise provider prices to commercial plans while not affecting the sums paid by Medicare.

ENCOURAGING ACO DEVELOPMENT IN AREAS FACING SOCIODEMOGRAPHIC CHALLENGES

LESSON TEN:

Special attention must be given to establishing ACOs in areas with social and economic challenges.

A considerable percentage of the health insurance expansion that will take place under the *Patient Protection and Affordable Care Act* will happen in areas that currently have high uninsurance rates and other health systems challenges. This will place strain on providers in these areas, who, as outlined in the text box below, already face challenges that impede their ability to deliver high quality healthcare. Consequently, public policy must pay special attention to the set-up of ACOs in areas with social and economic challenges.

Regional Performance Variation: The San Francisco Bay Area and the Inland Empire

California has a highly developed system of statewide annual performance evaluation for physician organizations. Over the past couple of years, this program has uncovered significant performance variation between these entities, which stems in part from organizational capabilities, but also from the socioeconomic and demographic environment in which the organizations operate. When organizational performance is aggregated to the regional level, the most striking differences are seen between the San Francisco Bay Area and the Inland Empire, two regions that are also vastly different in terms of geography and socioeconomics. The San Francisco Bay Area is a small cluster of six metropolitan counties located in coastal Northern California, with relatively strong sociodemographic and health system characteristics, while the Inland Empire, formed of two expansive counties broken up by a series of mountain ranges in the southern part of the state, has weaker indicators.

Table Two shows aggregate performance results from the statewide Pay for Performance program for physician organizations in the Bay Area and the Inland Empire. Measures upon which payments are

TABLE 1

Select Demographic and Health System Characteristics

Area Characteristic	Bay Area	Inland Empire
Per Capita Income	\$46,015	\$23,540
Percent of Persons Aged 25+ who have earned Bachelor's degree or higher	39%	16.3%
Percent of Persons of Hispanic or Latino Origin	22.1%	45.7%
Percent of Population in Medi-Cal	13%	19%
Uninsurance Rate	7.8%	15.1%
PCPs per 100,000 residents	79	40
Staffed Community and Acute Care hospital beds per 100,000	211	142

TABLE 2

Pay for Performance Domain Scores for Organizations in the Bay Area and Inland Empire Regions, Measurement Year 2008

Domain	Bay Area	Inland Empire
Clinical Quality (/100)	76.78	62.10
Patient Experience (/100)	83.44	78.81
IT-Enabled Systemness (/15)	13.61	7.30
Coordinated Diabetes Care (/20)	10.59	2.81

made are split into four domains that gauge an organization's clinical performance, patient experience, use of clinical information technology, and the coordination of care delivered to patients with Diabetes. In all domains, organizations in the Inland Empire have lower scores, on average, than organizations in the Bay Area. Across the state, lower performing organizations appear to be clustered in areas with identifiable sociodemographic and health systems challenges. Larger uninsured and Medicaid populations, as well as less consolidation in these provider markets, appear to lead to lower overall reimbursement, which leaves these organizations with less capital available for structural and process improvements.

Performance variation has galvanized health care stakeholders in this state, who have begun implementing improvement initiatives, including pay for improvement, which rewards performance improvements in addition to the traditional focus on target attainment, and quality improvement collaboratives targeted specifically at low-performing areas. Performance disparities highlight the importance of accounting for the fact that physicians have different starting points, and face different challenges in developing ACO capabilities. In order to succeed, organizations must be endowed with the resources they need to deliver effective patient care, both in terms of infrastructure development and quality improvement support.

CONCLUSION



The California health care system includes 285 prepaid physician organizations that coordinate patient care, are paid on a capitation basis, and report their clinical and financial performance to purchasers, regulators, and consumers. The state's 30 years of experience with these organizations offer important lessons for the national debate on payment reform, delivery system reform, and the role of Accountable Care Organizations. These lessons highlight both the opportunities and the risks inherent in these organizational forms, and it is important that the national health care debate take them into account, lest the contemporary initiatives miss demonstrated strengths and repeat avoidable mistakes.

Clearly, payment and organizational restructuring are necessary but not sufficient conditions for a high performing health care system. Attention needs to be paid to how ACOs relate to health insurance plans, how the coordination of care they offer is integrated into a system that values individual consumer choice, and how regulatory oversight can be used to promote rather than impede ACO development. In particular, the following lessons should help guide the national debate:

- ▶ A variety of organizational structures are effective at delivering high quality coordinated care; at least as important to success as structure are an organization's capabilities, culture, and infrastructure, as well as the alignment of goals between the organization and its individual physicians.
- ▶ In California, a range of relationships exist between physician organizations and hospitals. Alignment of incentives between physician organizations and hospitals offer important opportunities for performance improvements across the entire continuum of care.
- ▶ As a method of payment, capitation can be effective at encouraging coordinated care, but payment methods should vary across ACOs depending on an organization's ability to assume risk.
- ▶ Health plans acting in concert on payment methods and performance measurement helped facilitate the growth of California's provider organizations, and should also play an integral part in fostering ACO development nationally.
- ▶ ACOs are not a panacea for health care spending control.

- ▶ ACOs must be agnostic to insurance type; most provider organizations in California have focused on commercial, Medicare, and Medicaid HMO plans for their patients, but for ACOs to be viable across the country, mechanisms must be found to encourage PPO and traditional Medicare and Medicaid patients to use their services.
- ▶ Balancing patient choice with the desire to decrease costs and effectively coordinate care is difficult. California's experience underscores the challenge of promoting care coordination in an environment of unrestricted provider choice.
- ▶ Regulation of the financial solvency of provider organizations is important to ensure market stability.
- ▶ Consumer protections from capitated provider organizations need to be balanced, not overburdening.
- ▶ Special attention must be given to establishing ACOs in areas with identifiable social and economic challenges.

In addition to informing the national debate, California must re-assess the role of these large provider organizations in its healthcare delivery system. For many years, costs were lower in California than in other major states and, within California, costs were lower in the HMO products that relied on ACOs than in the PPO products that relied on non-integrated small physician practices. In recent years, however, this cost advantage has narrowed, resulting in a trend in commercial insurance enrollment away from the ACOs. Medicare and the state Medicaid program continue to be major sources of enrollment and revenues for California ACOs, but these organizations cannot subsist on government payers alone. Health plans need to structure their insurance products and benefit designs to foster cost- and quality-conscious consumer choice among competing ACOs, and between ACOs and small non-integrated physician practices.

The national debate over Accountable Care Organizations offers important opportunities for efficiency and quality improvement in health care. To realize these opportunities, the discussion needs to learn from the rich lessons of California with respect to payment and delivery system reform. Conversely, the California health care system now enjoys a new opportunity to examine its own experiences, compare them with lessons from elsewhere, and fashion an improved version of the California ACO ecosystem.

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About the Integrated Healthcare Association (IHA)

The Integrated Healthcare Association (IHA) is a not-for-profit multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care in California. IHA administers regional and statewide programs, serves as an incubator for pilot programs and projects, and actively convenes all healthcare parties for cross sector collaboration on health care topics. IHA principal projects include the California pay-for-performance program (the largest private physician incentive program in the U.S.), the measurement and reward of efficiency in health care, value based purchasing of medical devices, health care affordability, bundled episode of care payments, and accountable care organizations. For more information about IHA visit: www.iha.org



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