

Accountable Care Organization for PPO Patients

Challenge and Opportunity in California



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EXECUTIVE SUMMARY

The Accountable Care Organization (ACO) provisions in the 2010 Patient Protection and Affordable Care Act have stimulated considerable interest among physicians and hospitals in California, as they offer the potential to move the Medicare fee-for-service program towards the integrated provider systems already prevalent in the state. Partially in response to the proposed Medicare ACO initiatives, private health insurance plans are developing collaborative ACOs initiatives with medical groups and Independent Practice Associations (IPAs) that have a record of providing integrated, cost-effective care to HMO enrollees. Care coordination has long been a hallmark of the HMO product in California, but enrollment has been shifting over the past decade to PPO products that rely on consumer cost sharing, rather than provider coordination, to moderate costs. Now several major health plans with large PPO enrollee populations are seeking to transfer to that environment the same care coordination programs developed by physician organizations for their HMO enrollees.

This White Paper examines the challenges and opportunities facing contemporary efforts to adapt ACO principles and practices to the commercial PPO population in California. It builds on an earlier IHA White Paper that examined the record of medical groups and IPAs in coordinating care using ACO principles for the HMO population, including patients enrolled in commercial HMO, Medicare Advantage, and Medicaid managed care plans. Although these new ACO initiatives aimed at the PPO population are still in the early stages of development, and much work remains to be done, the basic outlines of the new plan designs and provider programs are readily visible.

LINKING PATIENTS TO PHYSICIAN ORGANIZATIONS

In order to effectively coordinate care, physicians must have a defined patient population for which they are responsible. Aligning PPO patients with an ACO presents a challenge, because patients can seek care from *any* physician within the insurer's network, including those outside of the ACO. This contrasts with the structure of the HMO insurance product in California, where each enrollee selects a primary care physician and thereby the medical group or IPA to which that physician belongs. The contemporary ACO initiatives in California assign (or "attribute") PPO patients to provider organizations based on where the patients obtained the majority of their care in the previous two years. This prospective attribution is superior to the retrospective attribution proposed by Medicare for its Shared Savings Program, because it allows ACOs to focus care coordination efforts on an identified group of patients. To the extent the patient does not reap any cost sharing advantages from using ACO physicians over non-ACO physicians within the PPO network, however, this attribution process provides only a weak linkage between particular patients and particular physician organizations.

NEW PRODUCT DESIGNS

The limits of attribution methods are a principal reason why health plans in California are developing new PPO products that encourage enrollees to select an ACO and obtain their care from physicians and hospitals associated within that organization. These new insurance products are in various stages of review and approval by the state Department of Managed Health Care (DMHC). A primary feature of these new product designs is that consumer cost sharing is “low” when the patient obtains services from a physician who is part of the patient’s chosen ACO, “intermediate” when the patient obtains services from a physician who is not part of the ACO but still part of the PPO contractual network, and “high” when services are obtained from a physician who is outside the PPO contractual provider network.

PAYMENT METHODS THAT REWARD VALUE

PPO plans traditionally pay physicians on a fee-for-service basis that rewards high-volume rather than high-value care. The new ACO initiatives have developed a three-part payment system that includes—but goes beyond—fee-for-service. First: traditional visits, tests, and procedures continue to be reimbursed on a fee-for-service basis directly to the physician or facility that provides the care. Second: the PPO plan pays the ACO a monthly sum to cover the costs of care management programs, as these programs cannot easily be funded out of fee-for-service payments. Third and most importantly: the ACO is eligible for supplemental bonus payments to the extent that the total costs of care for its PPO patients fall beneath the amount that they would be expected to incur in the absence of the active management of the attributed population. The expected expenditure target, which lies at the basis of the shared savings incentives, is calculated from past claims costs, trended forward using the claims experience of non-ACO providers in the PPO network. The shared savings component will evolve over time to partial capitation and other forms of population-based payment.

SHARED RESPONSIBILITY FOR CARE MANAGEMENT

Care management programs are essential to improving quality and moderating the cost of care. Physician organizations are delegated responsibility for these programs by HMO health plans in California, but PPO health plans have traditionally sought to perform them directly. A key component of the ACO initiatives is the step-wise transfer of authority for care management from the PPO insurer to the physician organization. This delegation is more difficult in the PPO than in the HMO environment, as the employers who purchase PPO coverage differ widely amongst themselves in the number and type of care management programs they wish to purchase. Self-insured employers, who constitute major purchasers for PPO products, sometimes carve care management out of the PPO product altogether and delegate it to a specialized vendor.

For these reasons it is difficult for the PPO plan to shift full authority and responsibility for care management to the ACO. Physician organizations tend to treat all patients in a similar fashion regardless of which care management programs their employers wish to purchase. It is difficult for the PPO plan to halt its own care

management programs for enrollees who are attributed to an ACO while continuing to perform those programs for enrollees who do not receive care from ACO-affiliated physicians. For these reasons, the transfer of responsibility for care management is shifting only gradually from the PPO to the ACO. Full transfer will occur only when the new PPO product designs are approved by the DMHC and purchased by employers, because they will explicitly feature care management programs managed by the ACOs. Even with these new products, however, it is likely that the PPO plans will retain a greater direct involvement in care management than do HMO plans.

COMMUNICATION WITH PATIENTS

The ACO must be able to communicate with its attributed PPO patients so as to educate them about the physicians and hospitals that comprise the organization and the availability of its wellness, disease prevention, and care management initiatives. Both the health plans and the physician organizations involved in the ACO are careful to emphasize in their communications with enrollees that the ACO's network and programs are options but not requirements. The enrollees retain the right to obtain care from providers outside the ACO, although under new product designs they would face higher cost sharing. Effective communication between the ACO and its attributed PPO enrollees is also vital for engaging the cooperation and enthusiasm of the patients in the process of care.

CLINICAL AND ADMINISTRATIVE DATA EXCHANGE

The ability to coordinate care relies on prompt and complete exchange of patient data between ACO providers and health plans. The foundation of contemporary ACO initiatives is a mutual commitment to this data exchange. The fee-for-service reimbursement method creates a claims data source on each interaction, including physician and emergency department visits, tests, procedures, drug prescriptions, and hospitalizations. This is a richer source of information than that generated under HMO arrangements, because capitation payment does not require the generation of detailed claims data. Under the new ACO initiatives, providers will have real-time information on the full scope of services being used by their attributed patients, a matter of importance if the ACO is to intervene early with preventive and care coordination programs.

PUBLIC POLICY AND REGULATION

The California Department of Managed Health Care has jurisdiction over ACO risk transfer agreements as part of its statutory mission to promote financial stability and protect patients. The DMHC may not allow capitation reimbursement to ACO providers under a PPO product unless the ACO complies with financial solvency requirements and other aspects of insurance regulation similar to those that govern HMO arrangements. Antitrust policy and regulation are also important for health plans and provider organizations wishing to collaborate on ACO development. The need for provider collaboration will encourage consolidation and joint pricing agreements, potentially resulting in anti-competitive behavior. Regulatory barriers must be identified and, if necessary, changed so as to promote the development and effectiveness of ACOs while ensuring quality, access, and financial solvency.

INTRODUCTION



Health insurance plans and physician organizations in California are currently experimenting with initiatives that encourage the extension of care management programs and practices from the HMO to the PPO population.

The 2010 *Affordable Care Act* focused on expanding insurance coverage and moderating cost growth through improved care coordination. The health reform legislation authorized the Centers for Medicare & Medicaid Services (CMS) to designate medical groups and affiliated hospitals as “Accountable Care Organizations” (ACOs) that will be rewarded for reducing costs and improving quality for Medicare fee-for-service beneficiaries. ACOs will be expected to manage the full continuum of care for patients, report and improve quality, and reduce the cost of care below targeted levels. To the extent they are able to achieve these goals, ACOs will be rewarded with a share of the savings generated.

The ACO provisions of the health reform legislation have stimulated considerable interest among physician organizations in California, who see therein a path by which they might apply their care management programs to the traditional Medicare program.¹ Some physician organizations also see in the ACO principle the potential for expanding programs developed for HMO enrollees to patients enrolled in commercial PPO insurance products, which resemble the Medicare fee-for-service program in many ways. The legislation also stimulated interest among commercial PPO insurance plans, which have been under pressure to moderate the costs of care as a means towards moderating the premiums they charge to employers and individuals. Their principal strategy for premium moderation over the past decade has been to increase copayments and deductibles, but they recognize that enrollees are not sympathetic to further increases in consumer cost sharing.

Health insurance plans and physician organizations in California are currently experimenting with initiatives that encourage the extension of care management programs and practices from the HMO to the PPO population. An initiative between Anthem Blue Cross and several physician organizations is furthest along the development path. Other health plans, including Aetna and Blue Shield of California, and other physician organizations—including Brown & Toland Medical Group, Santa Clara County Independent Practice Association (IPA), St. Jude Heritage, and Hill Physicians Medical Group—also are engaged in programs that could significantly expand the scope of ACO activity in the commercial PPO sector.

This White Paper is based on interviews and meetings with medical group leaders, health plan executives, regulators, and other stakeholders with an active role in the ACO debate in California. It builds on a previous IHA White Paper that focused on the scale, scope, and experiences of medical groups applying ACO principles to the HMO population. This paper identifies early lessons from ACO initiatives with Anthem and Monarch HealthCare, Sharp Community Medical Group, Sharp Rees-Stealy Medical Group, and HealthCare Partners Medical Group [see sidebar on study scope, page 5]. These lessons are used to highlight the challenges and opportunities that will face other efforts to apply care coordination principles to the PPO population.² It goes without saying that the health care market is very dynamic and that the nature and composition of ACO initiatives is changing constantly, and so some of the specifics discussed here will no doubt change over time.

Scope of Study

Numerous health plans, physician organizations, and hospital systems have expressed interest in developing Accountable Care Organizations and in applying care management principles to the commercially insured preferred-provider organization (PPO) population. Most of these initiatives are still in the early exploratory phase. In order to gain insight into the future challenges and opportunities likely to confront these Accountable Care Organization (ACO) initiatives, this study focuses on the health plans and provider organizations that appear to be furthest along in developing ACOs in California.

The most active ACO initiatives for PPO enrollees are those between Anthem Blue Cross—the largest health plan in California in terms of commercial PPO enrollment—and four physician organizations in southern California. The physician organizations,

their structure, the number of Anthem enrollees attributed to them for the purpose of the ACO, and the number of HMO enrollees in California for which the organizations already assume clinical and financial accountability (as an indicator of the scale and scope) are presented in the Table below. These attribution and enrollment data are as of July 2011. The ACO landscape is evolving rapidly, and these four entities are profiled because they were early movers in California, and are presented without judgment as to whether they or other entities will be the ACO participants in the future. Aetna and Blue Shield of California have also developed ACO relationships for their PPO enrollees with several independent practice associations (IPA) and integrated medical groups (IMG) in the state.

Organization	Structure ¹	Number of Attributed Anthem PPO Enrollees	Number of HMO Enrollees Served ²
HealthCare Partners Medical Group	IMG and IPA	42,000	647,000
Monarch HealthCare	IPA	27,000	225,000
Sharp Community Medical Group	IPA	11,000	140,000
Sharp Rees-Stealy Medical Group	IMG	6,000	140,000

1) Integrated medical groups (IMGs) are physician organizations that employ individual physicians in a clinic setting (the physicians may also be owners of the medical group through a partnership structure). Independent practice associations (IPAs) contract with health insurance plans on behalf of small physician practices, but do not employ the individual physicians.

(2) HMO enrollment data include commercial HMO, Medicare Advantage, and Medicaid Managed Care plans from Anthem and other health insurers.

Interviews for this paper were conducted between June and August 2011 with approximately 50 physician and administrative leaders in these four physician organizations, other medical groups and IPAs, Anthem and other health plans, regulatory agencies, employer insurance purchasers, hospital systems, and policy analysis organizations.

Information and insight during the researching and writing of the paper were provided by the IHA Editorial Advisory Board, with members from physician, hospital, insurer, and public policy organizations.

WHY “ACCOUNTABLE CARE” FOR THE COMMERCIAL PPO POPULATION?

The national debate over ACO principles has centered on the traditional Medicare program and the delivery system composed of small and non-coordinated physician practices. Despite strong initial enthusiasm, two significant obstacles have slowed the diffusion of ACO principles along the originally envisaged path. First, the Medicare program is enmeshed in a complex legal, political, and regulatory context that limits the ability of CMS to expeditiously define the structure of organizations to be

deemed ACOs, to provide capital support for infrastructure development, to form linkages between particular patients and particular ACOs, to develop provider payment methods that support care coordination, and to consider new benefit designs that encourage beneficiaries to cooperate with ACO programs. Second, most regions in the United States lack physician organizations that can easily take on the care coordination tasks envisaged under the ACO principle.

In contrast, private health plans and physician organizations can move much more rapidly to develop new organizational structures and payment methods. They encounter challenges of implementation, however, due to regulatory constraints, incompatible data systems, and the cultural legacy of past contractual disputes. The California health care market includes many organizations that already have, to various degrees, the physician leadership, administrative capacities, financial management skills, and clinical programs needed to become ACOs. Furthermore, the strong and successful presence of Kaiser Permanente in the California health care market stimulates other health plans to pursue collaborative efforts with physician groups as a competitive imperative.

ACO initiatives for the commercial PPO population fit in with the strategic goals of many physician organizations in California. IPAs and integrated medical groups need to extend their care management programs over larger patient populations so as to cover their administrative and clinical program costs. They want to be able to serve a broad spectrum of patients regardless of their insurance coverage: commercial HMO and PPO, Medicare Advantage and traditional Medicare, Medicaid managed care, and self-pay patients.

The ACO concept also fits in with the broader strategic goals of health insurance plans. They have relied on increases in consumer cost sharing to moderate the growth in premiums, but are reaching the limits of this tactic, as many potential enrollees increasingly see little benefit in high-deductible coverage. The limits of cost sharing are especially evident for patients suffering from chronic health problems, who are often unable to make the complex decisions as to which treatments are necessary and which are discretionary. Some health plans recognize the benefits of channeling enrollees to physician organizations with care management programs, but have been reluctant to do so under fee-for-service payment methods. ACOs rely on large physician organizations and provide them incentives to reduce the costs of care.

WHAT'S AT STAKE?

ACOs that bring together physician organizations and PPO insurance plans are important not only for the entities involved, but also for the nation as a whole as it seeks to balance two fundamental objectives in reforming the health care system.

First and most obviously, the health system is on a financially unsustainable trajectory that expands budgetary deficits and crowds out funding for wage growth, education, retirement programs, defense, and other important commitments. The Medicare fee-for-service program and commercial PPO insurance aggravate the system's inflationary tendencies by reimbursing providers on a basis that rewards increases in utilization and complexity, regardless of whether the services provided

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are appropriate. The care management and prospective payment methods developed by HMO insurance plans and medical groups in California can make a significant contribution toward reining in cost inflation if applied to the larger Medicare and PPO enrollee populations.

Second, and of equal importance, the American population is firmly committed to a strong role for the individual consumer in selecting providers and treatments, and is equally hostile to efforts that transfer those choices to any other entity, be that the government, insurers, employers, or anyone else. This resistance to top-down decision-making manifested itself in the backlash against the hard-edged version of managed care in the 1990s and in the more recent backlash against perceived efforts to create a governmentally dominated health care system. Principles of free choice in terms of provider and treatment are embedded in the Medicare fee-for-service and commercial PPO insurance products and account for much of their continuing popularity.

The ACO initiatives in Medicare and in the private insurance sector offer the opportunity to find a new balance between the imperatives of care coordination and broad consumer choice. To Medicare fee-for-service and commercial PPO enrollees, these offer the possibility of moderation in costs through enhanced coordination of care. To medical groups, ACOs offer a framework within which to improve their care coordination programs with a greater reliance on customer service and less reliance on administrative restrictions.

The ACO concept holds much promise, although its actual value will depend on the manner by which it is implemented. Early experiments are encouraging, but many key components still need to be put into place. Only time will tell whether health plans, medical groups, and patients are able to embrace these changes rather than permit the health care system to continue down its current path towards ever higher costs and ever more arbitrary payment cuts and coverage limits.

LINKING PATIENTS TO PHYSICIAN ORGANIZATIONS

Effective care coordination requires individual patients to be affiliated with physician organizations that are, in turn, responsible for the clinical quality and economic efficiency of their care. The physicians need to know the population for which they are accountable in order to identify patients with special needs, to direct them towards appropriate programs, and to ensure the collection, transfer, aggregation, and use of data from office visits, laboratory and radiology tests, hospitalizations, and drug prescriptions.

In the HMO context most familiar to California physician organizations, the linkage between patient and provider is accomplished by the patient's choice of a personal primary care physician and, thereby, of the medical group or IPA to which that primary care physician belongs. In the commercial PPO insurance context, however, there is no direct way for patients to be associated with physician organizations. Patients can choose different physicians from within the broad PPO contractual



network for each different visit or test, as desired, without any concern or attention paid as to whether those physicians have any organizational relationship with one another. As a consequence, physicians in these organizations do not have defined populations of PPO patients for which they can be held accountable.

The national debate on ACOs has sought to solve the challenge of linking patients to provider organizations by “attributing” each patient to the ACO whose member physicians provided the majority of that patient’s primary care visits or episodes of care over the previous year. The ACO would then be clinically and economically accountable for the entirety of these patients’ costs, including those incurred using physicians, tests, and other services outside the ACO. This embodies the principle that the ACO can or should engage the cooperation of the patients. In its current initiatives, Anthem attributes PPO enrollees to the medical group if the majority of the episode costs incurred by the patient over the past year are cared for by that ACO’s physicians.³

Effective care coordination requires individual patients to be affiliated with physician organizations that are, in turn, responsible for the clinical quality and economic efficiency of their care.

The proposed PPO Medicare framework attributes patients to providers on a *retrospective* manner.⁴ That is, the health plan waits until the end of a performance year to identify which patients should be attributed to which ACOs from the year that just ended, and holds the ACO accountable for the care provided in that year. Under this scenario, the ACO cannot identify patients with particular needs and direct them to particular services, nor can it seek to engage them in preventive programs and coordinate their care. In other words, it is accountable for an unknown patient population.

In the contemporary California ACOs, PPO patients are attributed to physician organizations *prospectively*, meaning that the medical group or IPA knows at the beginning of the year the patients for which it will be held accountable in the coming twelve months. Prospective attribution is flawed to the extent that patients often change health plans or provider organizations over the course of the year, and their ACO attribution is based on their pattern of care in the prior year. Over the long term, however, physician organizations insist on the need for PPO product designs in which each enrollee actively chooses and affiliates with an ACO. Using this perspective, the patient would still be able to pursue providers and treatments outside the selected ACO, but would be rewarded for staying within the ACO for most care through lower copayments and coinsurance.

The California PPO initiatives permit and encourage ACOs to reach out to attributed members, and avoid suggesting that patients’ choice of providers is being compromised. The backlash against HMO limits on specialty referrals, clinical tests, and other high-cost services has created an environment that promotes choice over coordination; and access over efficiency. This culture remains strong among many employers who purchase and many employees who select PPO coverage. It is unclear how many of the attributed PPO patients have chosen PPO over HMO coverage—and hence are actively resistant to provider channeling—and how many are covered by PPO insurance because they were not offered HMO coverage at all. Nevertheless, the initial letters from the ACOs to their newly attributed PPO patients emphasize that patients retain the right to use services from any PPO contracted provider, regardless of ACO affiliation, and that choosing an ACO provider

and the ACO's care coordination programs are options rather than requirements.

The limits of prospective and retrospective attribution are a principal reason for the development by Anthem and other health plans of new PPO product designs that will motivate enrollees to select a physician organization and then obtain most care from caregivers within that organization. PPO products of this type have been approved by the California Department of Managed Health Care (DMHC) for Blue Shield of California, and are under discussion for Anthem and Aetna, but none have appeared on the market yet. The new PPO products would impose lower copayments for visits and tests obtained from ACO member physicians, higher cost sharing for services obtained from physicians who are outside the ACO but still inside the PPO contractual network, and the highest level of cost sharing for physicians outside the PPO contractual network. These new products will include deductibles to permit lower premiums (in contrast to HMO products, which typically do not impose deductibles).

PAYMENT METHODS

PPO insurance reimburses physicians for their services based on a fee schedule that is either established unilaterally by the payer or negotiated between the payer and the providers. Fee-for-service payment creates incentives for providers to be productive in conducting office visits, inpatient services, and tests, but not to pay attention to the cost of care. Moreover, fee-for-service does not contain codes or other methods for reimbursing physician organizations for the costs of their care coordination programs.

The health plans and physician organizations participating in the California ACOs have negotiated an initial three-part payment structure that seeks to combine the productivity incentives of fee-for-service with the cost-control incentives of care management and shared savings. The first and largest component of the payment structure is the continued use of the negotiated schedule of fees paid to each physician for each service, as is done by the PPOs for their non-ACO providers. These fees are paid directly to the individual physicians and practices, rather than to the IPA or medical group organization. For integrated medical groups with employed physicians, the practice and the organization are the same entity.

The second component of the payment structure is a monthly fee paid to the IPA or medical group (not to the individual physician) to cover the costs of the organization's care management activities. This care management fee is based on the number of PPO members attributed to the organization. The principle underlying the per-member-per-month payment is that the ACO should be reimbursed prospectively for the costs of its care management programs, rather than be obliged to wait until shared savings are calculated and funded at some time in the future. The PPO is transferring the cost and responsibility of care coordination to the ACO, and must also transfer additional funding to cover the incurred expenses. This contrasts with the proposed regulations for the Medicare Shared Savings Program, which do not permit Medicare to pay for care coordination services outside of the shared savings pool.



Over time, some ACOs hope to be paid on a capitation basis for their attributed PPO patients, which can be interpreted as two-sided shared savings with full exposure to all losses and all gains.

The third component of the payment structure negotiated between the PPOs and the physician organizations is the one that attracts the most attention, as it offers the greatest potential for changing physician practice, and thereby reducing the cost and increasing the quality of care. Under this component, the health plan and ACO will agree on an annual target expenditure amount for the population of patients attributed to the ACO, based on historical claims costs projected forward using the claims experiences of non-ACO providers as the trend factor. The goal of the ACO would then be to use care coordination methods to reduce the actual level of expenditure below this target, and thereby generate savings compared to what otherwise would have been spent. These savings then can be divided between the health plan and the ACO according to a predetermined percentage split. Over time, this percentage split may change and other entities, such as partnering hospitals, could be allowed to share in the savings.

The shared savings component of payment is expected to evolve as the ACO becomes more familiar with the utilization patterns of its PPO patients (who may or may not exhibit utilization patterns similar to those of the HMO patients with whom the physician organizations are most familiar). As with the Medicare Shared Savings proposed rules, the ACO can be eligible for a share in savings from expenditures below the negotiated target while not being held responsible for “losses” from expenditures above the target (upside-only shared savings). Alternatively, the savings opportunity can be two-sided, with the ACO sharing in any losses (by reimbursing the health plan) as well as in any savings.

Over time, some ACOs hope to be paid on a capitation basis for their attributed PPO patients, which can be interpreted as two-sided shared savings with full exposure to all losses and all gains. However, the California Department of Managed Health Care (DMHC) has asserted jurisdiction over ACO risk-transfer agreements and would not permit capitation under PPO products unless the ACO was subject to financial monitoring and reserve requirements similar to a Knox-Keene licensed health insurance plan. These requirements would be burdensome for all but the largest physician organizations, although the need may be mitigated to the extent that risk transfer is moderated by stop-loss clauses and service exclusions that can be incorporated into PPO payment arrangements.

QUALITY AND EFFICIENCY MEASUREMENT



The ACO initiatives in California require reporting and performance on both quality and efficiency and seek to limit administrative burdens by using metrics that the physician organizations already collect on their HMO patients as part of the state’s Pay for Performance (P4P) Program, managed by the Integrated Healthcare Association (IHA). However, the IHA program does not currently include metrics on hospital performance and its metrics for physician organizations do not cover all the dimensions of performance of concern to the participating plans and physician organizations. The list of metrics adopted for the ACO initiatives in

California therefore overlaps in part but not fully with the IHA list (see the sidebar note on quality and efficiency metrics, page 12).

Performance on quality and efficiency metrics will be used in two ways. Adequate performance on some individual metrics will be used as a “gate” that must be passed before the ACO can obtain any shared savings from overall expenditures. Under this option, the fact that the ACO brought actual expenditures below the expenditure target is necessary but not sufficient to receive a share of the savings. Implicitly, participants agree that any aggregate “savings” obtained without making progress on the most obvious individual sources of savings (embodied in the efficiency metrics) is likely to be an artifact of chance or favorable risk selection rather than true change in provider practice patterns. They also agree that any savings obtained at the expense of quality deterioration would be undesirable and would not be shared.

The second way in which performance on quality and efficiency metrics will be used is as the basis of a supplementary bonus from the PPO to the ACO, over and above shared savings that derive from total expenditures. This second approach is consistent with the IHA’s P4P Program, under which health plans supplement the medical groups’ payments if the groups perform well on quality and efficiency metrics. The logic behind this approach is that ACOs should be rewarded for making progress on individual dimensions of performance even if these individual improvements fail to offset backsliding on overall expenditures.

CARE MANAGEMENT PROGRAMS

The ACO concept rests on the assumption that suitably organized and motivated groups of providers will be able to reduce health care costs below the trend expected from the cottage industry of fragmented practices. Potential savings will come from two principal sources. The most immediate savings are likely to come from the channeling of specialty consultations, tests, procedures, hospitalizations, and other interventions to providers willing to cooperate with, and moderate their prices to, the ACO. Medical groups and IPAs in California have extensive experience with channeling referrals and will extend that experience to the PPO population. The ACO physicians will need to rely more on persuasion than on mandate, which will require them never to take their patients’ cooperation for granted. This will be a challenge in the short term but likely an advantage in the long term, as the medical groups and IPAs transfer customer service skills honed on these newly affiliated PPO patients to their existing HMO patients.

The second source of potential savings, and the more substantial one over the long term, is the application of preventive and care management programs to PPO patients whose care has been episodic rather than coordinated. These programs include disease screenings and immunizations; shifting of care from hospital to non-hospital settings; management of hospital care by ACO-employed



Initiatives to influence physician performance through Accountable Care Organizations (ACOs) rely on the ability of health plans and providers to measure, report, and improve performance in quality and efficiency dimensions. Participants need to identify a set of metrics that can be derived from claims data, establish benchmarks for performance attainment and improvement, and agree on how performance on these metrics is built into the “shared savings” payment method. The proposed ACO regulations for Medicare mandate reporting on 65 quality metrics and state that attainment must be achieved on all 65 in order for an ACO to share any part of the savings for which it is responsible. In the context of ACO initiatives between private insurers and physician organizations, the definition, benchmark levels, and use of performance metrics is a matter of negotiation, not mandate. Both sides want metrics that cover multiple dimensions of performance, impose only modest administrative costs, and set the bar of attainment low enough to attract participation yet high enough to encourage performance improvement.

The collaborative ACO initiatives in southern California have agreed on an initial set of metrics and the manners by which they will be used. These include quality metrics for both physician and hospital services, as well as efficiency metrics that cover physician, hospital, and pharmaceutical expenditures. It should be noted that the metrics, benchmarks, and implications of attainment are still in development, and that there is variation among the physician organizations in what they can and will do.

Metrics on Quality and Efficiency

Table 1 presents the physician quality performance metrics agreed upon by Anthem Blue Cross and Sharp Community Medical Group (SCMG) in San Diego. These metrics are derived in part from the California Pay for Performance (P4P) Program, which is focused on physician organizations that serve the commercial HMO population. The P4P Program is administered by the Integrated Healthcare Association (IHA), in collaboration with eight health insurance plans and over 200 physician organizations. Anthem and SCMG participate in the IHA program and are familiar with the collection and reporting of these data and with programs to improve performance. In choosing these metrics, both sides place emphasis on limiting administrative

expenses by using well-established metrics. Using these metrics will also allow for comparisons of performance over time, across physician organizations, and between the HMO and PPO patients served by the same physician organization.

Table 2 presents the hospital performance metrics that have been discussed by Anthem and SCMG. These metrics are derived from a variety of sources and are already reported by some hospitals to some outside entities. However, the IHA P4P Program has not included hospital quality metrics to date; therefore no direct carry-over was possible. Because neither the administrative cost nor the potential benefit of these measures has been fully assessed, SCMG is reporting only its performance on these metrics and is not currently being held to any benchmark of attainment or improvement.

Table 3 presents the efficiency metrics that will be used to assess ACO efforts in slowing increases in the costs of care. These individual metrics complement the more basic measure of efficiency, i.e., the difference between expected aggregated costs for the attributed PPO population minus the actual experienced costs for that population. Some of these efficiency metrics are adopted from the IHA P4P Program, which has expanded to include efficiency metrics over the past several years. The efficiency metrics to be used by Anthem and SCMG include reductions in rates of

TABLE 1
Physician Quality Metrics (Ambulatory Care)

Measurement Focus	Treatment Goals
Prevention	Cancer screenings and childhood immunizations
Diabetes	Hemoglobin, cholesterol, and kidney function screenings
Cardiology	Cholesterol management
Imaging	Use of studies for lower back pain
Pediatrics	Testing for pharyngitis, treatment for upper respiratory infections
Pulmonary	Avoids antibiotic drugs in acute bronchitis
Medical Management	Appropriate monitoring of specified pharmacy drugs

TABLE 2

Hospital Quality Metrics	
Source of Metric	Area of Coverage
Joint Commission/Centers for Medicare & Medicaid Services (CMS) National Hospital Quality Measures	Acute myocardial infarction, congestive heart failure, pneumonia, Surgical Care Improvement Project (SCIP)
American College of Cardiology (ACC) metrics for Cardiology	Percutaneous coronary intervention, vascular access, lipid agents at discharge, etc.
Society of Thoracic Surgeons (STS) metrics for Cardiac Surgery	Deep sternal wound infection, prolonged ventilation, pre-op beta blockers
National Healthcare Surveillance Network	Central line infections, catheter for urinary tract infections, ventilator-associated pneumonia
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Patient satisfaction with care received in the hospital

use (e.g., avoidable emergency room visits, spine MRIs, hospital admissions per 1000 attributed enrollees per year), reductions in levels of expenditure (e.g., claims costs for spine or abdominal MRI), or changes in substitution rates (e.g., percent of prescriptions or prescription expenditures made for generic rather than brand drugs within therapeutic categories for which generics are broadly available).

Use of Performance Metrics

Benchmarks for attainment will be established empirically for each of the participating physician organizations through analysis of two years of past claims data on the PPO enrollees who have been attributed to each ACO. The ACO will be held to maintaining past performance levels (attainment of benchmark) or improving on them (improvement on benchmark), with the specifics agreed upon separately for different metrics.

Attainment and improvement on benchmarks will be used in a different manner for the quality metrics than for the efficiency metrics. The quality metrics will be used as a gate through which the ACO must pass to share any portion of the savings that it generates. In contrast to the Medicare ACO initiative, the ACOs working with the private PPO insurers need not reach full attainment or improvement on every metric in order to obtain any share of the savings. Rather, the percentage of the potential savings in which the ACO will share will increase with the number of quality metrics on which the ACO achieves attainment or improvement.

The efficiency metrics are to be used as a component of the shared savings pool rather than as a gateway to obtaining a share in those savings. It is possible that some types of expenditures will increase as part of the ACO's effort to reduce overall expenditures. For example, expenditures on freestanding ambulatory surgery centers may increase even as hospital expenditures and total health care expenditures decline. It may be, however, that total actual expenditures will not fall below total expected expenditures, resulting in no overall savings to be shared. In order to generate savings to be shared under the Anthem ACO initiative, SCMG must improve its performance on the individual efficiency metrics, not merely attain previous levels of total cost performance.

TABLE 3

Efficiency Metrics	
Measurement Focus	Treatment Goals
Emergency Department	Total avoidable visits per 1,000
Prescription Medications	Prescriptions, per-member-per-year Generic prescribing rate
Imaging	Spine MRIs per 1,000 Spine CTs per 1,000 Abdominal CTs per 1,000
Inpatient	Admits per 1,000 Days per 1,000 HEDIS—all cause readmission rate

Care management programs provide the foundation for ACO efforts to improve quality and reduce cost.

hospitalist physicians and inpatient management nurses; reviews and authorizations of specialist referrals and high-cost tests; disease management programs for patients suffering from chronic conditions such as diabetes; personalized care management programs for patients suffering from complex conditions such as renal failure; and home visits by ACO physicians and nurses to severely ill patients.

Care management programs provide the foundation for ACO efforts to improve quality and reduce cost but they, in turn, rest on the foundation of prompt, complete, and accurate exchange of electronic data between the health plan and the ACO. The fee-for-service payment methods used by PPOs generate a rich source of data on every office visit, procedure, test, prescription, and admission. These administrative claims data often are richer than the data available to the medical group for their HMO patients, since care for these patients is reimbursed on a capitation basis that does not require documentation of every clinical interaction.

Medical groups and IPAs can have varying roles in the creation, adjudication, payment, and reconciliation of claims and claims data, depending on their electronic data management capabilities. The more that the health plan delegates referral channeling and care coordination to the ACO, the more that the ACO needs to be involved in the claims process. The patient attribution and expenditure targets at the core of the shared savings goals are built on prior years' claims. More importantly, the achievement of savings requires that the ACO know which of its attributed patients are in the hospital, which ones are taking medications, which ones have chronic conditions for which they have not recently been treated, which ones have not yet received indicated preventive care interventions, and so forth. Much of the start-up energies devoted by the health plans and medical groups are in the domain of data exchange, timing, interpretation, and use.

RELATIONSHIPS WITH SELF-INSURED EMPLOYERS



While delegation of care management authority is a core component of an ACO, it faces meaningful obstacles and complications. It can be difficult to “turn off” care management programs at the health plan level for PPO patients attributed to an ACO while keeping the programs running for others. It is also unclear how accrediting organizations will view the outsourcing by the PPO of its care management programs to ACOs.

Self-insured employers that contract with PPOs for physician network access and claims payment often retain the right to purchase care management programs on an à la carte basis. Some purchase programs from the PPO, some purchase them from free-standing disease management companies, and some refuse to purchase them at all. They will now have the option also to purchase them from the ACO, as is done by the PPO itself through its per-member-per-month care management payment to an ACO. There is a risk that PPO patients attributed to an ACO may have duplicative

care management programs reaching out to them. The contemporary ACO initiatives in California avoid this problem by limiting the attribution to enrollees in the insured PPO products, to the exclusion of employees of self-insured firms.

Restriction of ACOs to enrollees in fully-insured PPO products to the exclusion of self-insured plans can only be a transitory solution, given the large numbers of patients coming from self-insured employers. If these employers and their employees cannot be brought into ACO-based products, the reach of care coordination into the health care system will be quite limited. Physician organizations and health plans are beginning to reach out to employers to explain the ACO concept and encourage their participation; this outreach is happening not only among medical groups and IPAs formally participating in ACOs, but also among IPAs seeking to forge relationships directly with self-insured employers. Brown & Toland Medical Group in San Francisco, for example, has obtained Federal Trade Commission approval to contract with PPOs on a fee-for-service basis due to its status as a clinically integrated provider organization; it pursues analogous relationships with self-insured employers.

The challenges posed to ACOs from self-insured employers extend to the concept of shared savings. Self-insured employers rely on insurers to contract with providers and perform administrative functions but not to bear financial risk. Rather, the employer pays provider claims directly. In the employers' view, as they pay all claims costs, all claims savings should accrue to them. There is no easy mechanism by which "savings" off expected costs can be shared with the ACO rather than appear simply as smaller outflows from the employer's bank accounts.

RELATIONSHIPS WITH HOSPITALS

In most American communities, the only health care organizations with the scale, financial strength, and management depth to undertake an ACO are the local hospitals or hospital systems, and so the Medicare Shared Savings Program envisages a central role by the hospital in ACO ownership, governance, management, and shared savings. In California, by way of contrast, there exist numerous physician organizations that already possess many features of ACOs and are potentially poised to expand their activities. The challenge facing the California entities is that many are no longer economically responsible for the care that is provided in hospitals. "Global capitation," which covers hospital services, shifts too much financial risk to medical groups and IPAs that may lack the scale and sophistication to manage the most expensive forms of care. Many medical groups are now paid via capitation for primary care and specialty physician visits and procedures, to the exclusion of hospital-based services. Lacking the financial incentive to manage high-cost hospital services, these medical groups and IPAs do not do so, and hence the average costs per patient are no longer substantially lower for HMO than for PPO patients in California.



Savings should be allocated across participants in the ACO endeavor in proportion to their effort and success in generating those savings.

Physician organizations in California manifest a broad range of hospital relationships, from vertically integrated “foundation models,” in which the medical group is essentially owned by the hospital, through various intermediate partnership relationships, to full autonomy of the medical groups from the hospitals. Close linkages between physician organizations and hospitals can be both a boon and a bane in the search for savings by an ACO. Many of the obvious targets for cost savings come at the expense of hospital revenues, including shifting care from inpatient to outpatient settings, shortening inpatient lengths of stay, reducing the use of tests and implantable devices for which the hospital is able to obtain attractive mark-ups from insurers, and the shifting of ambulatory procedures from hospital outpatient surgery departments to lower-priced freestanding surgical centers.

It is difficult for hospitals to acquiesce in the loss of revenues from commercial PPO patients, the last coverage group from which they have been able to obtain profit margins to subsidize low payment rates from Medicare, Medicaid, and uninsured patients. To the extent that hospitals are not included in ACOs, they may choose to reject them so as to hold onto their revenues. Several hospital systems—such as Catholic Healthcare West in Sacramento, St. Joseph of Orange in Orange County, and Sharp HealthCare in San Diego—are engaged in new ACO initiatives where options are being explored for the hospitals to protect their revenues and margins even as total expenditures for ACO patients are reduced.

The key question over the longer term is whether close hospital relationships are an advantage in managing the costs of hospitalized patients. If hospitals frustrate cost-control initiatives that reduce hospital revenues, they will undermine ACO collaborations between health plans and physician organizations. To the extent that they embrace ACO principles and programs, hospitals can accelerate the changes in use and cost that the plans and physicians are targeting. To the extent that hospital participation generates meaningful savings, it will be logical for the ACO to extend the shared savings program from the physicians to include the hospital. Savings should be allocated across participants in the ACO endeavor in proportion to their effort and success in generating those savings.

CONCLUSION



The Medicare Shared Savings Program is embroiled in debates over the appropriate balance of rules, regulations, and incentives and may not succeed in meeting its ambitious schedule. ACO initiatives in the commercial insurance context can take advantage of willing plans and provider organizations in particular geographic regions, and need not fashion a template that will work for everyone everywhere. These contemporary initiatives are still in the early phases of what may or may not prove to be significant change. Lest we suffer from the common error of overestimating short-term effects and underestimating long-term effects of new relationships, however, it is important to view these ACOs in light of the broader imperatives facing physician organizations and health plans.

For medical groups and IPAs in California, the imperative is to extend administrative and clinical capabilities from the HMO population to patients who are covered by commercial PPOs, self-insured employers, and the Medicare fee-for-service program. Enrollment in commercial HMOs has been shrinking and enrollment in Medicare HMOs is at risk if Congress cuts funding for the Medicare Advantage program. For IPAs, the federal push for ACOs has created a perspective on the part of antitrust regulatory agencies that is more open to collective negotiations between doctors and insurers, once combined with cost saving programs such as care management. For integrated medical groups, the ACO payment principles open the path to being paid for doing what these groups do best—coordinating care and managing costs—rather than being reimbursed through the fee-for-service payment scheme that rewards fragmented and costly patterns of care.

For health plans, ACOs offer the possibility of moderated cost trends, and hence premium trends, in ways other than continual increases in consumer cost sharing. Consumer cost sharing is important for discretionary and easily-understood services used by educated enrollees, but creates obstacles to necessary services used by less educated or capable patients. Moreover, consumer cost sharing may be facing its own regulatory backlash, as the federal government gropes towards a definition of “essential health benefits” that must be provided with little or no cost sharing and as media accounts of medically-related bankruptcies proliferate. ACOs are also a means for the health plans to make lemonade out of the lemons of provider consolidation, acknowledging that physician and hospital mergers are an ineluctable trend in the market. If done correctly, ACOs could motivate large provider organizations to pursue profitability by reducing costs rather than by raising prices.

For both providers and insurers, ACOs represent the opportunity to forge a middle ground between the traditional HMO product, which controls cost at the expense of consumer choice, and the traditional PPO product, which preserves choice at the expense of cost control. The ACO movement in California is building on the PPO platform, and hence begins with a broad network of providers, fee-for-service payment, and a soft approach to care management. To this it adds elements from the HMO context, including coordinated physician organization, payment methods that reward cost reduction, and a strengthening of care management programs. In much of America, the ACO debate is fraught with worries that the modest financial incentives will not stimulate the development of new provider organizations. California already has numerous physician organizations upon which ACOs can be built. It is now time for these physician organizations, and the health plans with which they contract, to overcome the challenges and fulfill the opportunities presented by the principles of Accountable Care Organizations.

NOTES

1. The interest among physician organizations in California has been primarily focused on the “Pioneer” ACO proposal, rather than on the original Medicare Shared Savings Program (MSSP) proposal. The former is designed to build on the capabilities of well-developed physician organizations, whereas the latter is designed for physicians and hospitals that have little experience with care coordination.
2. JC Robinson, EL Dolan. Accountable Care Organizations in California: Lessons for the National Debate on Delivery System Reform. Integrated Healthcare Association, 2010. <http://www.ihc.org>.
3. This contrasts with the proposed Medicare ACO initiative, which would attribute patients to ACOs based on the majority of the patient’s office visits, rather than episodes of care.
4. The proposed regulations for the Pioneer initiative would allow the ACO to select either prospective or retrospective attribution logic, in contrast to the MSSP initiative regulations, which would only permit retrospective attribution.

About the Integrated Healthcare Association

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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