Accountable Care in California: Imperatives and Challenges of Physician-Hospital Alignment

James C. Robinson, Ph.D, Leonard D. Schaeffer Professor of Health Economics, University of California, Berkeley; Director, Berkeley Center for Health Technology

INTRODUCTION
The promise of Accountable Care Organizations (ACOs) is to improve outcomes and reduce expenditures by better coordinating each patient’s care. This coordination depends on close alignment between physicians and the hospitals they use for inpatient care and for ambulatory surgical and diagnostic procedures. Many medical groups are now defining themselves as ACOs and seeking new relationships with hospital partners that see closer physician alignment as essential to their new focus on population health.

Aligning physicians with hospitals extends beyond forms of organization to methods of payment. New payment methods are creating incentives for ACOs to manage the total cost of their patients’ care—including hospital admissions, length of stay, ambulatory surgery, diagnostic imaging and laboratory tests. Reduced costs to physician organizations often translate, however, into reduced revenues to their hospital partners. Hospitals thus face revenue reductions while being asked to invest in ambulatory services and to continue funding charity care, clinical research and other socially beneficial activities. This Issue Brief analyzes physician-hospital alignment in the California health care market as ACO methods of organization and payment are taking hold.

THE CALIFORNIA CONTEXT AND CHALLENGE
Close collaboration between medical groups and hospitals, often sealed through joint ownership, can improve data transfer, reduce duplicative testing and promote smooth patient transitions from ambulatory to inpatient, post-acute and community settings. Hospitals can serve as strategic partners for medical groups, offering the financial capital and managerial expertise needed to succeed in a complex environment.

ABOUT THIS ISSUE BRIEF
This Issue Brief analyzes physician-hospital alignment in the California health care market as ACO methods of organization and payment are taking hold. Related Issue Briefs address other aspects of ACOs emerging in the state, including:

▪ A Large Community Health Center Adapts to a Changing Insurance Market, by Jill Yegian, Ph.D
▪ ACO Contractual Arrangements in California’s Commercial PPO Market, by Thomas R. Williams, Dr.PH, and
▪ Referral Management and Disease Management in California’s Accountable Care Organizations, by James C. Robinson, Ph.D.

Background on the underlying case study and descriptions of the physician organizations included are in the Appendix.
However, joint ownership may also impede rather than promote efficiency. Hospital systems with the financial capability to acquire medical groups are often those with strong market positions and the ability to charge the highest rates to health insurers. Once they purchase a medical group, they usually expect the physicians to select the high priced parent facility for patients who need hospital care. Hospitals are often unenthusiastic about the prospect of seeing their Medicare fee-for-service and commercial PPO patients come under payment methods that reward reductions in admissions and length of stay. They are also reluctant to see ambulatory surgery and diagnostic procedures move from their outpatient departments to competing freestanding ambulatory centers.

The risks facing medical groups that align with hospital systems in California were underscored in a recent study revealing that the total cost of care per patient was 10 percent higher in medical groups owned by a local hospital than in independent medical groups, after adjusting for differences in patient case mix, local supply costs and other relevant factors. Also, the cost of care was 20 percent higher in medical groups owned by multi-hospital systems, compared to independent physician organizations.1

Ownership and Alignment
All physician organizations in this study emphasized not only the importance of close working relationships with the hospitals where their patients obtain inpatient care, but also the challenges of aligning cultures and financial incentives. The most immediate cost targets for the physician organizations lie in:

- reducing inappropriate hospital admissions
- shortening lengths of stay through efficiently transition- ing patients to other sites of care
- providing oversight of inpatient care by the organization’s hospitalist physicians rather than by non-affiliated specialists from the hospital’s medical staff
- ensuring patients do not use expensive hospital emergency departments for after-hours care, and
- favoring low-cost freestanding centers over high-cost hospital departments for ambulatory procedures.

Each of these pits the physician organization’s interest in lower costs against the hospital’s interest in higher revenue. Of the groups studied for this Issue Brief, St. Joseph Heritage Healthcare thrives due to the brand name and resources of the St. Joseph hospitals with which it is affiliated; the others choose to remain independent of hospital ownership and, in two cases, to affiliate with organizations that compete with hospitals for physician affiliation. HealthCare Partners and Monarch HealthCare are core entities within Davita and Optum, the two leading non-hospital consolidators of physician practices in the nation.

Approaches to ACO Contracting
California differs from many other states with its long history of medical groups that accept capitation and responsibility for medical management, traditionally embodied in relationships with commercial and Medicare Advantage HMOs. In this state, the contemporary interest in ACO contracting is fueled by the efforts of established physician organizations to expand beyond HMOs into managing care for patients in commercial PPO and Medicare fee-for-service programs. The medical groups in this case study have each pursued different tactics in restructuring payment.

- AltaMed continues to expand its enrollment of patients from commercial and Medicaid HMOs, and is not pursuing commercial PPO or Medicare ACO contracts.
- Brown & Toland Physicians has been the most active in pursuing commercial PPO contracts using the ACO rubric, and has been a strong participant in the Medicare fee-for- service ACO program. This reflects the rapid decline in commercial HMO enrollment in San Francisco and the relatively low enrollment in Medicare Advantage plans, which forces the IPA to look elsewhere for patients. HMO and Medicare Advantage enrollment remains stronger in Southern California.
- HealthCare Partners initially embraced the Pioneer ACO model, but subsequently reduced its involvement after being at risk to incur financial losses, and now has a Medicare Shared Savings Program (MSSP) contract. It has an ACO relationship with the PPO products of CIGNA and Anthem Blue Cross, but continues to work especially closely with those insurers’ HMO products.
Monarch HealthCare has participated in the Medicare Pioneer ACO program, but prefers to work with Medicare Advantage plans rather than the Medicare ACO models.

St. Joseph Heritage Medical Group has not seen value in pursuing ACO contracts for PPO patients and continues to emphasize the advantages of switching to HMO coverage.

Challenges of Data Connectivity

Physician organizations depend on nearby hospitals to notify them quickly when a patient is admitted or arrives at the emergency department—an essential step for a physician to begin managing a patient’s case and if appropriate, shift it to a lower-cost site of care. Inpatient notification and care management have been central components of the “delegated model” of managed care and HMO contracts in California for decades. The HMOs require hospitals to notify the delegated medical groups immediately if a patient arrives at the emergency department or is admitted for inpatient service. Under the new ACO contracts outside the HMO framework, however, the hospital has no such obligation. The hospital may feel comfortable having the patient’s care managed by its medical staff specialists rather than make a special effort to inform and involve the ACO.

Monarch cited data interchange as a potential benefit of developing a partnership with the MemorialCare hospital system, with which it historically had only a contractual relationship. Monarch and MemorialCare are now forging a more strategic partnership, aimed at improved quality and lower cost, to compete with the highly integrated Kaiser Permanente system. Monarch has invested considerable resources to obtain real-time data on Medicare ACO admissions of the sort it routinely obtains for its Medicare Advantage patients. HealthCare Partners admits patients to more than 30 hospitals in Southern California, and cannot be aligned with only one or two systems. However, it continues to develop strategic partnerships with several key institutions, building on the foundation it has with these hospitals through managed care HMO relationships.

Challenges of Shared Savings and Capitation

The physician organizations in this study all prefer global capitation—under which hospital as well as physician services are paid on a prospective basis, over the shared savings models—under which physicians are eligible for only a share of any reductions in hospital expenditures related to spending targets.

HealthCare Partners accepts a shared savings contract as an alternate to global capitation, as a different means to fund the infrastructure in support of population health management.

St. Joseph Heritage has rejected shared savings contracts with Medicare or commercial insurers, preferring to expand global capitation through Medicare Advantage plans and commercial HMOs.

Monarch and Brown & Tolland are both committed to the Medicare FFS ACO initiative, but see it as weaker and less desirable than Medicare Advantage in reducing cost growth.

The physician organizations in this study all prefer global capitation over the shared savings models.

HealthCare Partners views managing hospital admissions as a core component of its overall strategy, given the wide variation in prices at academic medical centers such as USC and UCLA, major local institutions such as Huntington Memorial and Torrance, and the many smaller community hospitals in Los Angeles and Orange County. The organization developed a payment model with some hospital institutions that mimics global capitation, aligning the financial interest of the hospital with the medical group’s incentives to reduce unnecessary inpatient expenditures. HealthCare Partners directs admissions to partner facilities that consistently demonstrate appropriate use of ambulatory surgical centers and coordinated patient discharge planning.

St. Joseph Heritage acknowledges the short-term disadvantages of using expensive hospital departments for ambulatory surgery and imaging, but views the brand-name advantage as more than compensating. Heritage has worked to convince the St. Joseph hospitals to accept global capitation contracts in lieu of fee-for-service or per diem payment, reducing their incentive to resist reductions in admissions and lengths of stay. For the past decade, the hospitals had resisted capitation for hospital services, limiting the Heritage medical groups to capitation for physician services only.
A major concern is patients using hospitals outside the St. Joseph system, for which Heritage would be required to pay full Chargemaster prices if it accepted capitation from the HMOs for hospital services. This was of particular concern relative to pediatric patients. The St. Joseph Health system recently developed a partnership with the Children’s Hospital of Orange County to avoid paying list prices for inpatient pediatric services. The St. Joseph hospitals now are willing to enter into global capitation contracts alongside the Heritage medical group. The hospital system is not in a hurry to shift PPO patients to HMO coverage, however, which limits Heritage's interest in accepting a shared savings contract from commercial PPO plans.

Brown & Toland has resisted partnering with the Sutter Health hospital system in San Francisco to form an integrated delivery system, since Sutter charges high prices to insurers—inadvertently impeding its affiliated medical groups’ abilities to earn shared savings. Brown & Toland notes approvingly that Sutter Health recently entered into a capitation agreement with one insurer in San Francisco and that several Sutter-affiliated medical groups have signed ACO contracts with PPOs in other parts of Northern California. To hedge its bets, however, Brown & Toland also collaborates with the Dignity Health hospitals and the UCSF medical center, which compete with Sutter Health in the San Francisco market.

**POTENTIAL ROADBLOCKS TO COST-SAVING MEASURES**

The largest potential savings in the contemporary health care market come out of the pockets of hospitals, and while these savings are significant in principle, they are difficult to obtain in practice. With the formation of ACOs, the hope is that physicians have more direct means to restrain hospital costs, by channeling patients to lower-cost facilities, shortening length of stay and preferring ambulatory settings, than do insurers. However, they face significant challenges.

- **Higher hospital prices.** Some hospitals have raised their prices significantly with insurers over the past decade, based on mergers that reduce competition and more aggressive negotiations that leverage the reduction in competition to an increase in price. There is now wide variation in inpatient prices across hospitals and hospital markets, and selecting a particular hospital for the patient's admission has a major impact on the total cost of care. Hospitals charging high prices tend to have strong balance sheets, so are most capable of buying medical groups. Hence the physician community is being aggregated into high-priced rather than low-priced delivery systems. A hospital that purchases a physician organization typically expects it to use the parent's facilities.

- **Medicare incentives.** Hospitals face financial incentives from Medicare to reduce the average number of days patients are hospitalized, since they are paid on a per-case basis independent of length of stay. However, commercial PPO plans typically pay on a fee-for-service or per-day basis. For these patients, longer lengths of stay are profitable for the hospitals, as actual treatment costs tend to decline after the first few days of the admission. Hospitals are reluctant to see these patients covered by ACO contracts that motivate physicians to quickly discharge patients to home or other post-acute settings.

- **Hospital-based clinics.** Hospitals have diversified into ambulatory clinics, charging higher prices to Medicare and commercial insurers than freestanding surgical and diagnostic centers. Such services include same-day surgery, diagnostic radiology such as MRI, after-hours urgent care, clinical laboratories and infusion centers for specialty drugs. Hospital-owned physician organizations are under pressure from their parent hospital systems to prefer hospital-based services over competing freestanding centers.

**LOOKING AHEAD**

The experiences of the physician organizations in this study suggest that progress toward cost stabilization through ACO contracts from Medicare and commercial PPO has been modest at best. Longer-term success may require stronger financial and contractual incentives, similar to commercial HMO and Medicare Advantage plans.

Many Medicare fee-for-service and commercial PPO enrollees are currently indifferent to the price differences charged at competing facilities, see no value to quick discharge after inpatient care, and prefer hospital-based centers for ambulatory services due to the easily recognized brand names. Many patients who have eschewed commercial HMO and Medicare Advantage in favor of loosely managed fee-for-service insurance are not interested in care management, even for well-identified chronic conditions. The health plans have sought to avoid a backlash against
ACO incentives in their PPO products analogous to the one against managed care incentives in HMO products in the 1990s. In their ACO payment methods for PPO and Medicare fee-for-service patients, the insurers have been minimizing primary care gatekeeping, utilization management and the other limitations on consumer choice.

The physician organizations in this study have made some inroads toward ACO contracts for Medicare fee-for-service and commercial PPO patients. But the real changes in costs will depend on stronger incentives and management—and on policymakers and employers willing to embrace the goals of coordinating care and reducing costs.

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Note

Acknowledgments
This project was supported by a grant from the Robert Wood Johnson Foundation. The author would like to thank the Foundation, the ACO Case Study Team and all of the health plans and physician organizations that contributed their valuable time and insights to this Issue Brief.
**APPENDIX**

**Background and Methodology**

**ABOUT THIS STUDY**

This Issue Brief and three others draw upon information from a case study conducted by the Integrated Healthcare Association (IHA) and researchers from the University of California at Berkeley, School of Public Health. Support for the two-year study, which was launched in April 2013, was provided by a grant from the Robert Wood Johnson Foundation® and focused exclusively on the California market. The research team conducted two rounds of structured interviews in 2013 and 2014 with five prominent Accountable Care Organizations (ACOs). It also undertook two rounds of interviews with health plan executives responsible for ACO strategy and contracting at five health plans in California: Aetna, Anthem, Blue Shield of California, CIGNA and UnitedHealthcare.

**PHYSICIAN ORGANIZATIONS INCLUDED**

This study focused on five physician organizations—each distinct in scale, geography, structure and ownership ties to hospitals. All are deeply engaged in ACO initiatives, defined broadly as including payment methods linked to the total cost of patient care. Some have new ACO contracts with Medicare and private insurers, while others are focused on capitation payment from Medicare Advantage, commercial HMO and managed Medicaid plans.

- **AltaMed Health Services** was founded more than 40 years ago as a grant-funded free clinic serving the Latino population in Los Angeles. It is the largest independent Federally Qualified Health Center in the U.S., delivering more than 930,000 annual patient visits to 180,000 patients through 43 sites in Los Angeles and Orange Counties. The majority of AltaMed’s patients—85,000—are Managed Medi-Cal enrollees, but it serves an additional 11,500 through Medi-Cal fee-for-service contracts. In addition, 26,000 patients are covered through commercial HMO and PPO contracts, and 5,000 are Medicare patients. AltaMed provides care through staff-model clinics with an IPA that supplements the clinic staff with community physicians. It offers primary medical care, dental care and senior long-term care services.

- **Monarch HealthCare** is an IPA that includes 640 primary care physicians throughout Orange County. It serves 61,000 Medicare patients, of which 38,000 come through Medicare Advantage plans and 23,000 through its Pioneer ACO contract, plus 61,500 Medi-Cal patients through the CalOptima managed care program and 92,000 commercially insured HMO and PPO patients, combined. It is owned by Optum, Inc., a subsidiary of the UnitedHealth Group that also has an affiliation with the UnitedHealthcare insurance plan. Monarch does not have an ownership association with any hospital system, but admits patients to all the major facilities in Orange County and Los Angeles. Through Optum, it is also involved with payment and organizational initiatives for a larger set of medical groups across the nation.

- **HealthCare Partners**, a division of DaVita HealthCare Partners, manages and operates HealthCare Partners Medical Group in California along with organizations in Arizona, Colorado, Florida, Nevada and New Mexico. In California, HealthCare Partners serves 175,000 Medicare patients, including 125,000 through Medicare Advantage, and the remainder through its Medicare Shared Savings Program (MSSP) ACO and the Medicare fee-for-service program. It also serves 100,000 commercial PPO patients, 400,000 commercially insured HMO patients and 117,000 Medi-Cal managed care and fee-for-service patients. For HMO and Medicare Advantage patients, HealthCare Partners is paid capitation for the full range of physician and hospital services. HealthCare Partners contracts with nearly 50 hospitals in Southern California.

- **Brown & Toland Physicians** is an Independent Practice Association (IPA) founded in 1992 in San Francisco, with a recent expansion into the East Bay market. Its 1,500 physicians care for more than 34,000 Medicare patients—including 16,000 through Medicare Advantage and 18,000 through its Pioneer ACO contract. It also serves 100,000 commercial HMO patients through capitation contracts; 175,000 commercial PPO patients; and 2,700 Medicaid managed care enrollees. Brown & Toland partners with several hospitals in the area, including Sutter, where many admits come from California Pacific Medical Center and Alta Bates Summit Medical Center. It also partners with other area hospitals—including Dignity Health, the University of California, San Francisco and the Alameda Health System.
This Issue Brief focuses on findings related to four physician organizations: Brown & Toland Physicians, HealthCare Partners, Monarch HealthCare and St. Joseph Heritage Medical Group. A fifth, AltaMed, was also included in the study, but because of its unique structure as a community clinic, the results are addressed more specifically in a separate Issue Brief:

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**RESEARCH TEAM MEMBERS**

The research team was comprised of:

- **Thomas R. Williams**, Dr.PH—Vice President and General Manager of Accountable Care at Stanford Health Care; Former President and CEO at the Integrated Healthcare Association
- **James C. Robinson**, Ph.D—Leonard D. Schaeffer Professor of Health Economics at the University of California at Berkeley School of Public Health and Director of the Berkeley Center for Health Technology
- **Jill Yegian** Ph.D—Senior Vice President, Programs and Policy at the Integrated Healthcare Association,
- **Kimberly MacPherson**, MPH, MBA—MPH Program Director, Health Policy and Management at the University of California at Berkeley School of Public Health and Co-Director of the Berkeley Center for Health Technology, and
- **Kelly Miller**—Project Manager at the Integrated Healthcare Association.

**ISSUE BRIEFS PRODUCED**

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