

Arranged Marriages: The Evolution of ACO Partnerships in California

Introduction

In response to the federal Patient Protection and Affordable Care Act of 2010 (ACA), hospitals, physicians, and other providers across the country are collaborating with public and private payers on new delivery system and payment reforms intended to slow health care spending growth and to improve quality of care. Among these, Medicare initiatives to develop accountable care organizations (ACOs) — groups of providers that take responsibility for the cost and quality of care of a defined patient population — have spurred interest in similar, commercial ACO contracting arrangements (see “What Is a Commercial ACO Arrangement?” on page 2).

California ranks first among states in commercial ACO contracting arrangements, with at least 14 as of May 2013.¹ A longitudinal study of six California health care markets by the Center for Studying Health System Change (HSC) provided a unique opportunity to examine commercial ACO development in the state. Blue Shield of California introduced the state’s first commercial ACO arrangement in Sacramento in 2010, between the first round of the study in 2008 and the second round in 2011–12. An examination of the six communities found that market factors unique to California — large physician organizations experienced in managing financial risk for patient care, along with competitive pressure on both insurers and providers from the growing dominance of Kaiser Permanente Health Plan — have helped drive interest in developing ACO agreements in California.

Unique market conditions also have shaped ACO design differently in California than elsewhere. While most ACO initiatives nationally focus primarily on new provider payment approaches that are incorporated into existing insurance products, initial California ACO collaborations have combined payment changes with new limited-network ACO insurance products.^{2,3} These limited-network products include financial incentives for enrollees to use ACO providers; they typically are structured either as health maintenance organization (HMO) products that restrict patient access only to ACO providers or as preferred provider organization (PPO) products with reduced patient cost sharing for using ACO providers.

Limited-network ACO products are not developing uniformly across the state, however, because insurers and providers are assessing the business case on a market-by-market basis. Differences in insurer and provider market structure and competition in each community, among other factors, have affected the pace of development. Initial experiences suggest that while some significant savings are possible, ACO efforts require intensive collaboration and investment to support care management and exchange of sensitive performance data. These commitments present challenges even in California communities where market conditions are more favorable for ACO development than elsewhere in the country.

This paper explores the factors that have spurred ACO activity in California since 2008, describes how the state’s

commercial insurance market has affected ACO product design, and identifies market conditions in local communities that affect ACO product development and structure. The analysis also considers how market factors are likely to affect the evolution of commercial ACO arrangements in California and the rest of the country.

The California Context for ACOs

California has much higher commercial HMO enrollment than most other regions of the country.⁵ California HMOs typically restrict patients to seeking care only from HMO providers, and patients must select a primary care clinician who serves as a gatekeeper, limiting opportunities for patient self-referral. Kaiser has by far the largest commercial HMO

What Is a Commercial ACO Arrangement?

ACO initiatives are part of a group of payment reforms currently being implemented that attempt to transition from volume-based, fee-for-service payment toward value-based payment linked to quality and efficiency standards. The ACO model — in contrast to episode-based or service-specific reforms, such as bundled payments or reference pricing — seeks to address total spending across the continuum of care. Under innovative arrangements, private insurers contract with ACOs — which include physician networks and sometimes hospitals and other providers — that agree to be responsible for the cost and quality of care of a defined patient population.⁴ Many commercial ACO efforts are built on PPO platforms, although some ACOs in California and elsewhere use HMO platforms. Typically, under an ACO contract, a global budget for health care spending is set for the covered population, and ACO providers share cost savings with the payer if spending is under budget. Some ACO providers also share losses if spending exceeds the budget. These incentive arrangements are layered on top of existing payment methods, which typically are fee-for-service, with some exceptions, particularly in California where provider risk-sharing is more common.

In many areas of the country, commercial ACO efforts are similar to Medicare ACO programs — including the Medicare Pioneer ACO initiative and the Medicare Shared Savings Program — designed to address some aspects of capitation that helped spur the managed care backlash of the mid-1990s, including:

- ▶ **Provider Choice.** To avoid limiting provider choice and self-referrals, patients are not required to select specific ACO providers in advance nor are they restricted to seeking care solely from ACO providers. To measure provider performance on meeting

spending targets and other ACO objectives, insurers must “attribute” patients to providers based on where patients most commonly receive care. ACO providers face challenges managing care, such as controlling referrals and service use, because there is no gatekeeping built into the ACO arrangement, and ACO providers typically do not know in advance with certainty which patients they are responsible for under the ACO. In contrast to Medicare and to many commercial ACOs elsewhere, California’s initial ACO efforts are new limited-network insurance products that provide incentives for patients to use ACO providers. Also, offering ACOs as limited-network products may eliminate the need for patient attribution.

- ▶ **Quality.** To help curb the potential for stinting on care when financial incentives are linked to reducing service use, ACO providers must meet quality standards before they can share in savings.
- ▶ **Performance Risk versus Insurance Risk.** To minimize the potential for provider financial instability, provider incentives are focused on improving clinical performance and reducing unnecessary use rather than on managing insurance (actuarial) risk.

ACO proponents hope that the payment model will evolve, along with related delivery system organization, so that ultimately providers can assume full risk for health care spending. There is little evidence to date, however, on how effectively ACO initiatives in any form will be able to control health care spending and improve quality in the long run.

enrollment in California (58% market share), with enrollees receiving care almost exclusively from Kaiser-affiliated physicians and hospitals.⁶ The next three largest HMOs — offered by Anthem Blue Cross, Blue Shield, and Health Net — are all network-model HMOs; together, they account for only about half as many commercial HMO enrollees (28%).⁷

California network-model HMOs also are distinguished by the use of the delegated-capitation model, under which the insurer shifts financial risk and utilization management to large physician organizations (POs). In return, the POs accept professional capitation, which is a fixed per-member, per-month payment for primary care and specialty physician services and ancillary services, such as laboratory and imaging, regardless of the actual amount of services used. Enrollees in network-model HMOs select a physician organization in the network, which is then responsible for managing the patient's care, including referrals to other providers.

The prevalence of the delegated-capitation model — for Medicare Advantage and Medi-Cal managed care plans as well as for commercial HMOs — has supported the development of large POs in California. While some of these POs are large multispecialty group practices, many physicians who remain in small private practices are able to participate in HMO networks through independent practice associations (IPAs), which support HMO contracting and related care management services.⁸ The relationships of large POs — medical groups and IPAs — with health systems range from having near-exclusive relationships with a single system to working more at arm's length with multiple systems.⁹

While California has a large percentage of providers accepting financial risk for professional services, HMO contracts rarely put POs at risk for hospital services, and POs have few financial incentives to control hospital spending.¹⁰ Hospitals typically are paid using per diems or other fee-for-service methods. Only a limited number of hospitals — for example, Sharp HealthCare hospitals in San Diego and Sutter Health hospitals in Sacramento — have capitated

contracts for commercial HMO and Medicare Advantage plans, and these contracts represent only a small percentage of these hospitals' total revenues. Both health systems have closely aligned medical groups and IPAs to help manage care under these contracts.

Competitive Pressures to Control Costs

California commercial ACO collaborations, while still fledgling, reflect a marked change in insurer-provider relationships since 2008. At that time, relationships between commercial insurers and providers were typically arms-length, adversarial to varying degrees, and focused primarily on rate negotiation. Large hospitals and physician organizations were successfully exercising market leverage with insurers, which in turn were largely passing cost increases on to employers.¹¹

Insurers began cautiously pushing back against provider leverage by selectively introducing lower-premium, limited-network products.¹² Rather than collaborating with providers, insurers unilaterally developed two types of limited-network products: (1) narrow-network HMOs, which excluded high-price providers, and (2) tiered-network PPOs, which relegated high-price providers to non-preferred tiers requiring higher patient cost sharing at the point of care. In the limited number of study sites where these products were initially introduced, they often were built around a major, lower-price provider, while competitors with considerable market clout — such as Sutter Health in Sacramento and Scripps Health in San Diego — were either excluded from the network entirely or placed in more costly tiers.

The California Public Employees' Retirement System (CalPERS), the largest health purchaser in the state, was a significant catalyst in pressuring insurers to launch multiple efforts to reduce spending and premium growth — including developing limited-network products. Once insurers developed new products for CalPERS, they began seeking broader commercial outlets for the products; rival

insurers also started developing limited-network products as a competitive response. Many initial product offerings had promising receptions. Nonetheless, insurers were uncertain at the time whether products that limit access to major providers in return for lower costs would gain enough market share to be viable in the longer term. Since 2008, changing state and local market conditions — along with continued escalation in health care spending and the passage of national health reform — have set the stage for California insurers and providers to collaborate on commercial ACO products that build on these first-generation limited-network products.

Growing Kaiser Market Share Drives Insurers to Consider ACOs

One of the primary market pressures for insurers to collaborate on ACO products in California is the need to compete on price with Kaiser, the dominant HMO. In 2008, commercial insurers were already facing a steady decline in HMO market share because of increasing competition from Kaiser. Kaiser was beginning to successfully position itself as the benchmark for value by not only offering lower-premium HMO products but also by improving its reputation for quality. Other lower-priced PPO products, including lower-premium, consumer-directed health plans, added to this competitive pressure.

Since 2008, Kaiser enrollment has grown even as employer-sponsored health coverage on the whole contracted with the economic downturn, further shrinking non-Kaiser HMO market shares and pressuring lower-price PPOs as well.¹³ To compete with Kaiser, insurers expanded limited-network product offerings within and across most of the six sites in this study. However, insurers recognized the need to go beyond this approach by designing new ACO products, since focusing networks on lower-price providers can yield one-time savings but may not necessarily lower premium trends or increase competitiveness relative to Kaiser in the longer term.

Physician Organizations Seek to Expand Risk-Sharing

Because Kaiser is a closed-network HMO, providers, as well as insurers, view it as a major competitor. As a result, Kaiser's growth has been a major factor driving large hospitals and POs to consider collaborating on ACO efforts. POs reported that the shrinking base of non-Kaiser capitated enrollment has been particularly challenging for them because capitation is more profitable than fee-for-service contracts. IPAs face even greater financial pressure than medical groups when HMO enrollment shrinks. Because antitrust laws restrict IPAs to managing risk-bearing contracts only, IPAs have a smaller base of capitated enrollees over which to spread fixed costs, while medical groups have a broader base that also includes PPO enrollees and Medicare fee-for-service beneficiaries. As a result of shrinking capitation, POs — especially IPAs — have been aggressively exploring opportunities to diversify their business lines and to expand enrollment through ACO arrangements.

Hospitals Seek New Ways to Manage Total Cost of Care

Providers — particularly hospitals — have additional incentives to consider commercial ACO participation because of downward pressures on their bottom lines under health reform, even as coverage expansions increase the number of paying patients. Sources of pressure include reduced Medicare and Medi-Cal payments; the expectation that, to compete on price, commercial insurers will offer limited-network products in the state health insurance exchange; a potentially unfavorable shift in payer mix from commercial insurance toward lower-paying Medi-Cal and exchange plans; and Medicare's move toward value-based purchasing, including its own ACO initiatives.

Large providers with market leverage have already begun to accept lower payment rate increases so that commercial insurers' premiums can be more competitive with Kaiser. Furthermore, respected health systems widely regarded as high price, including Sutter Health and Scripps Health, have publicly acknowledged that they are pursuing multiple

strategies not only to lower hospital costs — with an eye to breaking even on Medicare — but to reduce the total cost of care across the continuum.

Pilot ACO arrangements provide hospitals and affiliated POs with an opportunity to experiment with managing the total costs of care. Large health systems, in particular, view the current market environment, in which they are doing relatively well financially, as a transitional period. They have the opportunity to test the waters in what is still largely a fee-for-service environment, taking advantage of their current financial cushion to experiment with new approaches, including ACO efforts, and absorb any initial losses from them. Moreover, like hospitals and health systems, large independent POs, which also have been doing well financially, see this as a transitional time in which to explore ACO initiatives.

The Particular Nature of California’s ACOs

Changing market conditions have motivated insurers and providers in California to engage in selected ACO collaborations to meet a common set of goals: maintaining affordability, competing more effectively with Kaiser, and positioning themselves for health reform. In some parts of the country, ACO efforts are focused on developing new provider payment approaches in existing insurance products. Initial California collaborations underway during this study, however, took the form of new, lower-premium, limited-network HMO-based ACO (HMO-ACO) and PPO-based ACO (PPO-ACO) products. (See Table 1.) These limited-network products include benefit designs to require or encourage enrollee use of ACO providers, as well as new payment approaches. HMO-ACOs, in particular, are intended to compete directly with Kaiser.

In structuring ACO products, each insurer is building on particular strengths in product design and market share. Blue Shield and Health Net — historically focused on HMO

Table 1. Commercial ACO Arrangements in Six California Markets as of May 2013

Market/ Date of Product Introduction	Insurer	Participating Provider Organization(s)	Product Type/Name	Purchaser Role	Covered Lives	Providers Also in Medicare Pioneer ACO Initiative or Medicare Shared Savings Program (MSSP)
Sacramento						
January 2010	Blue Shield	Hill Physicians Medical Group (IPA), Dignity Health (hospitals)	Limited-network HMO ¹	CalPERS	41,000	None
January 2011	Health Net	Sutter Health Sacramento Sierra Region (includes medical group, IPA, and hospitals)	Limited-network PremierCare HMO ²		Unknown	None
San Diego						
December 2011	Aetna	Sharp Community Medical Group (IPA) ³	Limited-network PPO		2,855	Pioneer
January 2012	Anthem	Sharp Community Medical Group (IPA), Sharp Rees-Stealy Medical Group	Limited-network ACO Core and Flex 3-Tier PPOs		22,000	See above

Note: Shaded ACO products were being offered at the time of the study. Other products were introduced after the study interviews were completed in April 2012.

1. Blue Shield also rolled out Blue Groove, a three-tiered PPO product in Sacramento County in Feb. 2012, which builds on the existing HMO-ACO.

2. Health Net introduced SmartCare, a narrow-network product similar to PremierCare, in Los Angeles, San Diego, and San Bernardino Counties in March 2012.

3. Sharp HealthCare hospitals and Sharp Rees-Stealy Medical Group plan to join this ACO, expanding its membership to 5,000 covered lives.

Table 1. Commercial ACO Arrangements in Six California Markets as of May 2013, *continued*

Market/ Date of Product Introduction	Insurer	Participating Provider Organization(s)	Product Type/Name	Purchaser Role	Covered Lives	Providers Also in Medicare Pioneer ACO Initiative or Medicare Shared Savings Program (MSSP)
San Francisco Bay Area						
July 2011	Blue Shield	Brown & Toland Physicians (IPA), Sutter Health-California Pacific Medical Center	Limited-network HMO	San Francisco City and County Employees Health System	23,000	Pioneer
October 2012	Cigna	Brown & Toland Physicians (IPA)	Existing commercial products ⁴		7,200	See above
January 2013	Aetna	Brown & Toland Physicians (IPA)	Existing PPOs		9,750	See above
July 2011	Blue Shield	Hill Physicians Medical Group (IPA), Dignity Health (hospitals), UCSF Medical Center	Limited-network HMO	San Francisco City and County Employees Health System	5,000	None
July 2012	Blue Shield	John Muir Health (includes medical group, IPA, and hospitals)	Existing HMOs	Includes but is not exclusive to CalPERS enrollees	17,500	MSSP
July 2012	Cigna	Sutter Health-Palo Alto Medical Foundation (medical groups and IPA)	Existing commercial products		34,000 (includes Alameda, San Mateo, Santa Clara, and Santa Cruz Counties) (Most enrollees outside study site)	None
Los Angeles						
May 2010	Anthem	HealthCare Partners (medical group and IPA)	Limited-network ACO Core and Flex 3-Tier PPOs		45,000 (includes Los Angeles and Orange Counties) (Most enrollees in study site)	Pioneer ⁵
April 2013	Cigna	HealthCare Partners	Existing commercial products		23,000	See above
October 2012	Blue Shield	Access Medical Group, St. John's Health Center	Existing HMOs	Includes but is not exclusive to CalPERS enrollees	7,000	None
Riverside/San Bernardino						
December 2012	Aetna	PrimeCare Medical Network (IPA)	Limited-network PrimeCare Physicians Plans HMO and PPO		140	Pioneer ⁵
Fresno						
None						

Note: Shaded ACO products were being offered at the time of the study. Other products were introduced after the study interviews were completed in April 2012.

4. ACOs based on existing products target plan enrollees already assigned to primary care physicians in the participating physician organizations.

5. In July 2013, these IPAs announced they were leaving the Pioneer ACO initiative after one year of participation, but did not indicate at the time whether they would transition to the MSSP program or exit altogether.

Sources: Cattaneo & Stroud Inc., *ACO Activities in California*, accessed June 17, 2013, www.cattaneostroud.com; respondent interviews; insurer and provider press releases; personal communication between authors and insurers.

products — are developing narrow-network HMO-ACOs, while Anthem and Aetna are developing tiered-network PPO-ACOs. Insurers also are focusing ACO initiatives on geographic regions where they have the strongest presence; for example, Blue Shield is concentrating on Northern California markets, while Anthem is focusing on Southern California.

Insurers typically have collaborated with one group of ACO providers in each market by launching a single ACO product. Among providers, it's typically large IPAs that have led ACO efforts rather than medical groups or hospitals; most of these IPAs also participated in at least the first year of the Medicare Pioneer ACO initiative, with the notable exception of Hill Physicians Medical Group. During the time of this study, some hospitals participated in HMO-ACOs (and Medicare ACO programs), but none participated in a PPO-ACO. To ensure that ACO networks have adequate geographic breadth and scope of services, hospitals and other providers may be included in the network, even if they are not partnering with the insurer and PO on the ACO itself.

Most ACO products are piloted on relatively small, well-defined, fully insured populations, with the stated intent of expanding the programs to broader populations if the pilots prove successful. For example, the Blue Shield CalPERS HMO-ACO in Sacramento was piloted using an existing HMO, with the participating population being CalPERS members already assigned to Hill Physicians, which is the ACO PO. After positive results with this pilot, the HMO-ACO product was offered to all CalPERS members in Sacramento and has since been replicated in other markets.

Unlike the underlying first-generation, limited-network products they are built on, ACO products include mechanisms to align financial incentives among insurers and participating providers. This alignment seeks to reduce overall spending while mitigating existing incentives each party has had to maximize its own payments and shift costs to others. To price ACO products competitively, the parties agree to a global budget that lowers the premium growth

rate, with some of the reduction passed on in the form of lower total provider payments. To meet the savings target, new financial incentives are layered over existing provider payment methods and rates rather than renegotiating them directly. Most ACO products include shared savings among participating ACO providers and the insurer if spending comes in under budget, provided certain quality metrics are met. HMO-ACO initiatives typically include shared losses as well. In these initial ACO efforts, payment rates to individual medical groups, physicians, or hospitals in the ACO network have not changed. Both insurers and providers have expressed interest in moving toward global capitation in the future, for both HMO-ACOs and PPO-ACOs, which would include payment for all services across the care continuum.

Examples of ACO Design

Certain differences in ACO product design are driven by whether the platform is an HMO or a PPO. Two of the most prominent ACO products in the six study sites — the Blue Shield CalPERS HMO-ACO in Sacramento and the Anthem PPO-ACO in San Diego — highlight key design differences, such as provider participation and risk-sharing arrangements. (See Table 2 on page 8 for more details.)

Blue Shield CalPERS HMO-ACO. The longest operating and most well-known California ACO product is a collaboration among Blue Shield, Hill Physicians (an IPA), and Dignity Health, with the second-largest number of California hospitals after Kaiser (as of 2010). While Hill contracts directly with HMOs, it has a close referral relationship with Dignity. A pilot ACO arrangement was launched in 2010 with 41,000 CalPERS members in the Sacramento area. The CalPERS ACO created a provider-plan partnership by applying a new incentive structure over the existing narrow-network CalPERS HMO, called Net Value, that already excluded Sutter Health and other higher-cost providers. A signature feature of this ACO product is that all three parties — insurer, physician organization, and hospital — are sharing in savings and losses relative to the global

Table 2. Differences in California HMO-ACO and PPO-ACO Product Design

	Blue Shield CalPERS HMO – ACO in Sacramento	Anthem PPO – ACO in San Diego
Network	Narrow network including Hill Physicians Medical Group and Dignity Health Sacramento hospitals	ACO Core (small-group product): ACO providers only (Sharp Community Medical Group and Sharp Rees-Stealy Medical Group, Sharp HealthCare hospitals, other smaller hospitals to provide geographic breadth) ACO Flex (large-group product): ▶ Tier 1: ACO providers ▶ Tier 2: Traditional PPO network ▶ Tier 3: Out of network
Patient Incentives	PCP gatekeeper model with no out-of-network coverage	Small-group product: no out-of-network coverage Large-group product: lower out-of-pocket costs for lower tiers
Attribution	N/A	Initially relying on attribution algorithm to assign patients to providers. Enrollees sign up for an ACO core physician organization during open enrollment so once there is sufficient enrollment in the limited-network product, attribution will no longer be needed.
Payment	Hospital: continued fee-for-service Physician organization: continued capitation Physician organization, hospital, and insurer: three-way shared risk pool (upside and downside risk). Spending targets are set by service category (facility, professional, mental health, drug, ancillary) with relative proportion of risk/benefit allocated in each category based on each partner's ability to influence spending in that category. Providers must meet quality standard.	Hospital: continued fee-for-service Physician organizations: continued fee-for-service, with higher reimbursement for evaluation and management services; additional per-member, per-month fee paid to physician organization for care management services. Physician organizations and insurer: shared-savings pool if costs are below benchmark (only upside benefit shared, based on efficiency metrics; no shared downside risk). (Hospitals are not ACO participants.) Providers must meet quality and efficiency standards.

Sources: Respondent interviews; Paul Markovich, "A Global Budget Pilot Project Among Provider Partners and Blue Shield of California Led to Savings in First Two Years," *Health Affairs* 31, no. 9 (September 2010).

budget. The formula to allocate risks and benefits is based on a joint assessment of each partner's ability to influence spending in each service category — facility, professional, mental health, drug, and ancillary. CalPERS received an upfront premium credit, which came from all three parties, thereby providing further motivation for all to meet spending targets.

Anthem PPO-ACO. One of Anthem's first PPO-ACOs in California launched in San Diego in 2011. A collaboration of Anthem, Sharp Community Medical Group (an IPA), and Sharp Rees-Stealy Medical Group, the product has 22,000 enrollees. In contrast to the Blue Shield HMO-ACO, the affiliated Sharp HealthCare hospitals are not participants in the Anthem PPO-ACO, although they are the main providers of hospital services in the ACO network. Under this model, POs are paid a care management fee and share in any savings with the insurer once they meet

quality thresholds. POs were not yet sharing in any downside risk. Anthem agreed to share its savings with employers by lowering future premium increases.

For providers, limited-network ACO products offer an opportunity to protect and possibly expand market share — if the products see enrollment growth — in return for accepting lower overall payments. For IPAs specifically, PPO-ACOs provide an opportunity to expand beyond supporting only HMO contracts.¹⁴ By structuring PPO-ACOs as tiered-network products and requiring enrollees to select an ACO provider upfront, attribution may not be needed to identify the covered population, unlike Medicare ACO programs and commercial PPO-ACOs elsewhere. However, enrollees can still see other non-ACO providers, albeit at a higher level of cost sharing. This makes it more difficult for providers to manage the patient's total cost of care in a tiered-network PPO-ACO than in a narrow-network HMO-ACO.

Hospitals' Reluctance to Join ACOs

Since reduced hospital use is the primary way to meet ACO spending targets and to generate shared savings, hospitals have a strong disincentive to participate in either type of ACO. Reductions in admissions and length of stay may more than offset any gains in volume from directing new enrollees to the hospital. Hospitals face an additional revenue squeeze if they institute new care management techniques that drive down use for non-ACO patients as well. If a hospital forgoes participation in an ACO, but POs that refer to that hospital do participate, the hospital's volume could be negatively affected, and the hospital would miss out on sharing in any ACO savings by not participating.

The net effect of a PPO-ACO on hospital volume is more complex to assess than with an HMO-ACO. Hospitals' market-share gain may be less in a PPO-ACO than in an HMO-ACO, since enrollees can still seek care from other network providers. But hospitals still may be able to boost fee-for-service revenue if ACO incentives — for patients and POs to keep care within the narrow ACO network — help improve “patient stickiness” and reduce typical PPO loss of patients to other facilities for elective procedures. Given the uncertainty about how to best align hospital incentives under a PPO-ACO, Sharp HealthCare, for example, adopted a wait-and-see attitude for its hospitals during the study period. Despite Sharp's joint participation with its POs in a Medicare Pioneer ACO, the system opted not to renegotiate its hospital PPO contracts when its affiliated physician organizations began PPO-ACO collaborations with Anthem and Aetna. More recently, however, Sharp hospitals and the Sharp medical group decided to join Sharp's IPA in the Aetna PPO-ACO contract.

Assessing ACO Potential Market by Market

Considerable geographic differences in market pressures across California, along with insurers' use of limited-network products as the foundation for ACO collaborations, have led insurers and providers to consider the business case for specific partnerships on a market-by-market basis. The result has been dramatic variation in the extent of ACO activity across the six regions studied.¹⁵ At one extreme is Sacramento, which saw the first ACO in California and which has served as a laboratory to test out new models and relationships. At the other extreme is Fresno, with no ACO collaborations to date. Comparing the six regions, it is clear that a combination of market factors has affected the ability and willingness of insurers and providers to form viable ACO collaborations in a particular community.

Strong Kaiser Presence

One of the most significant market factors in the establishment of ACOs is the degree of competitive pressure exerted by Kaiser on other health plans in a given community; the more dominant Kaiser's presence, the stronger the incentive for other plans to develop new products at lower premiums to maintain market shares. In all the markets studied with an ACO, Kaiser is a major and growing competitive force, while in Fresno, with no ACO, Kaiser's presence is more marginal.

As important a market factor as Kaiser's presence is, perhaps equally important is whether the insurer interested in forming an ACO collaboration has a large enough presence in a community to support an ACO product. One health plan executive estimated that a health plan must have commercial enrollment of at least 15,000 in a community before ACO products can be viable.¹⁶

Availability of Large, Price-Competitive Providers

Another prerequisite for the formation of viable ACO collaborations is the availability in a community of relatively low-price providers that are willing and able to form the

basis of a limited network. Markets with the most ACO activity are those with large POs that have experience in and enthusiasm for accepting capitation. In particular, these markets have large IPAs — for example, Hill Physicians in Sacramento and Sharp Community Medical Group in San Diego — that are aggressively seeking to protect or expand enrollment. Just as important, these POs are closely aligned with relatively low-price hospital systems — Dignity Health in Sacramento and Sharp HealthCare in San Diego — that provide the scale, range of services, and geographic breadth to support a limited network.

In markets without such close hospital-physician alignment, it is much more difficult for health plans to collaborate with providers on a viable limited network. In Los Angeles, for instance, HealthCare Partners is a large and growing IPA with sufficient geographic coverage to support ACOs, but the region's fragmented hospital market required the IPA to piece together hospital partners for its ACOs instead of forming a close alignment with a single large system as was possible in Sacramento and San Diego.

In San Francisco, Dignity Health is considered a lower-price provider than either the University of California, San Francisco (UCSF) Medical Center or Sutter Health's flagship hospital, California Pacific Medical Center (CPMC), but Dignity's two community hospitals lack the full range of services to serve as the sole anchor for a limited-network product. Also, Hill Physicians had only a minimal presence in San Francisco until a few years ago, when its market share was bolstered by an alliance with UCSF. As a result, Blue Shield could not serve the needs of its large client, the San Francisco Health Service System (SFHSS), which purchases benefits for San Francisco public employees, solely by forming an ACO network built around Hill and Dignity, as it had in Sacramento. Instead, Blue Shield had to piece together two ACO networks to serve SFHSS: one with Hill, Dignity, and UCSF, and the other involving Brown & Toland Physicians (an IPA) and Sutter's CPMC hospital. This lack of a lower-price, full-service, region-wide provider

in Los Angeles and San Francisco is a major reason these markets lag Sacramento and San Diego in commercial ACO development.

Sufficient Competition

Even more than San Francisco, the East Bay has lagged in commercial ACO activity. On the insurer side, while Kaiser's presence often stirs the drive for ACO creation, some market observers suggested that Kaiser's presence in the East Bay — at least in Alameda County — is so dominant that rival insurers have insufficient HMO enrollment to support a commercial ACO product. As for providers, Kaiser and Sutter's Alta Bates Summit Medical Center dominate in Alameda County. Observers suggested that Alta Bates Summit so far has faced so few non-Kaiser competitive threats that Sutter has little incentive in the East Bay, in contrast to San Francisco, to participate in ACO collaborations to curb inpatient utilization. That may change, however, as improved transportation infrastructure (a tunnel expansion) is expected to ease travel between Alameda and Contra Costa Counties, making it easier for Contra Costa's John Muir Health, which formed an ACO product with Blue Shield in 2012, to compete against Alta Bates Summit.

In markets with the most ACO activity, participation by major providers in early ACO products triggered competitive responses from higher-price rivals. In Sacramento, for instance, Sutter responded to the participation of Dignity and Hill Physicians in the CalPERS HMO-ACO by collaborating with Health Net on a narrow-network HMO product (PremierCare Network). Under this new arrangement, payment methods remained unchanged, but Sutter reportedly accepted reduced payment rates. While the product did not incorporate any new ACO-like financial incentives, the parties collaborate on data sharing and care management, as in other commercial ACO efforts. In San Diego, where Sharp is the centerpiece of many health plans' narrow-network products and has gained enrollment at the expense of other providers, Scripps was motivated to focus

on reducing costs and to reconsider its decision to abandon capitation. While Scripps has not gone as far as Sutter in forming a similar narrow-network product, it reportedly is exploring new collaborations with insurers.

Purchaser Demand

The role of purchasers in ACO development has been inconsistent across markets. In Sacramento, CalPERS was a major catalyst in the formation of California's first ACO product. In San Francisco, SFHSS was able to use the CalPERS Sacramento ACO product as a template when it sought development of its two ACO products with Blue Shield. In other markets, however, purchasers have not played a direct role in ACO development. San Diego — the market leader in limited-network products and ACO activity, along with Sacramento — had no single large purchaser fueling ACO growth. Instead, San Diego had a different competitive dynamic: a large number of acutely price-conscious small employers willing to accept limited-network products in exchange for premium savings.

Other Community Differences

Among the six California markets studied, Riverside/San Bernardino and Fresno stand out as having the least ACO activity. The two markets share some features that inhibit ACO interest and activity, including sprawling geography and weak economies contributing to an undersupply of physicians and a lack of hospital competition in geographic submarkets. As a result, neither market has providers with sufficient scale and geographic breadth to serve as potential anchors for narrow-network products.

On the other hand, these two markets also differ in key ways: Riverside/San Bernardino has a significant and growing Kaiser presence and some sizable POs taking capitation, unlike Fresno, where physicians continue to practice independently and remain unaligned with other physicians or with hospitals. This difference likely explains why

Riverside/San Bernardino has had some recent, albeit very limited, ACO activity, while Fresno continues to have none.

ACOs Present Benefits and Challenges

While limited-network ACO products include incentives to slow premium growth and improve care delivery, insurers and providers report that these commercial ACO products also create challenges and incur costs for participants. For example, these ACO initiatives themselves do not prescribe specific approaches for slowing spending through delivery system changes; ACO participants are experimenting with the same broad range of care delivery redesign and cost-cutting strategies that non-ACO providers are exploring.¹⁷ On the other hand, these ACO products do provide important new incentives for participating insurers, POs, and hospitals to work together to manage care and contain costs across the continuum of care. The intent of this “virtual integration” is to emulate what Kaiser has been able to achieve as an integrated delivery system.

Infrastructure and Process Change

Despite long experience with the delegated-risk model, participants are finding that effectively supporting ACO efforts requires expanding investments in expensive infrastructure and care management tools, along with rethinking existing processes. For example, Hill Physicians reportedly invested at least \$1 million in additional infrastructure and staffing to strengthen case management and to reach out preemptively to high-risk patients in the CalPERS HMO-ACO. All three CalPERS ACO participants — Hill Physicians, Dignity Health, and Blue Shield — previously had separate, concurrent inpatient review processes. Once the ACO pilot was underway, however, the partners realized they would need to collaborate to more efficiently and effectively reduce inappropriate hospital use. Ultimately, responsibilities (and associated costs) were reallocated, with hospital staff monitoring inpatient stays and

IPA staff focusing on improving transitions to the outpatient setting.

Data Exchange

Participants in HMO-ACOs and PPO-ACOs have stressed the need for and value of data exchange among ACO participants, but also its challenges, such as cost, technical barriers, and trust. PO access to new sources of clinical and administrative data to manage patients — for example, data on inpatient use and out-of-network use — is a substantial benefit of ACO participation. However, the lack of interoperability among the information technology (IT) systems of insurers, POs, and hospitals impedes the integration of data to manage care most effectively. Moreover, while California POs have sophisticated IT infrastructures to aggregate and analyze data to manage HMO risk contracts, HealthCare Partners, Brown & Toland, and other POs are making costly modifications to these systems to support PPO-ACO contracts because of differences in the way patient information is captured in the underlying HMO and PPO platforms.¹⁸

Insurers and providers also reported the benefits of sharing what is often highly sensitive performance data to identify and address cost drivers. Such transparency requires building trust among parties that are typically working to maximize their own organization's outcomes. The fault lines on this issue were revealed when Anthem dropped a pilot ACO partner, Monarch HealthCare, an IPA in Orange County, after the IPA was acquired by a subsidiary of UnitedHealth Group, because of concerns that Anthem data might be shared with the competing insurer.

The Role of Hospitals

Nowhere is the trade-off between benefits and challenges more apparent than with ACO opportunities to decrease hospital spending, which present a barrier to hospital participation. National observers have mixed opinions about the role hospitals should play in ACOs. Some suggest

that ACOs with hospitals or health systems in the lead on the provider side may be less successful, as bottom-line considerations are likely to hinder hospital willingness to work with ACO partners to curb inpatient use.¹⁹ However, PO-led ACOs have only limited ability to influence hospital spending without hospitals as ACO partners.²⁰ POs can influence hospital admissions through their member physicians and, if they have their own hospitalists, some inpatient spending. In theory, they also have the ability to steer business elsewhere if they are not satisfied with hospital care and costs. But referral patterns are rarely easy to shift in the short run, and the use of limited networks in California ACOs means that POs have to work with insurers to identify hospitals for the ACO network as it is being developed, resulting in the network being locked in for some period. Moreover, the alternative of structuring an ACO without a hospital partner may limit the magnitude of cost savings because POs do not have the same ability as hospitals to control underlying input costs or per-admission spending. Also, an ACO without a hospital partner would have more limited access to important data, especially in real time.

In California, hospitals are deciding about participating in ACOs on a case-by-case basis, but the process promises to be dynamic. Early experience from the CalPERS HMO-ACO suggests that hospitals can play a key role in working with POs to identify and address cost drivers. To help gain Dignity Health's participation, however, Blue Shield and Hill Physicians agreed to drive more referrals to Dignity Health's outpatient facilities to help offset the system's inpatient losses. And while Sharp HealthCare hospitals initially decided not to participate in any PPO-ACOs with affiliated POs until the bottom-line effects are better understood, the hospitals recently joined an existing PPO-ACO collaboration.

Doubts About Long-Term Savings

While ACOs may be successful in initially producing savings, the jury is still out on whether the savings rate can be sustained over time, given how ACOs are currently

structured. The CalPERS HMO-ACO was the only contract in place long enough at the time of this study to have performance data publicly available. In the first two years, Blue Shield, Hill Physicians, and Dignity Health met spending targets and generated savings.²¹ In 2010, the premium growth rate was held to 0%, with CalPERS receiving a premium credit of \$15.5 million and the ACO partners sharing an additional \$5 million. In 2011, the premium trend was up but was significantly less than what other HMOs experienced, and again the partners shared savings.

However, some participants expected that generating the same level of savings moving forward is going to become increasingly challenging, once the easiest efficiencies have been achieved. If so, then setting shared-savings goals based on the past performance of participating providers will not be sustainable in the long run unless it is possible to expand enrollment by bringing in new, previously unmanaged lives, or if different metrics are used to set savings targets, for example, regional spending.²² Furthermore, it remains to be seen whether these ACO products will be popular enough with purchasers and consumers to yield the market-share gains that insurers and providers are betting on to make these efforts financially viable.

Implications for Future ACO Development

In many ways, California is at the vanguard of developing commercial ACO collaborations. Insurers and providers in California are motivated to collaborate by Kaiser's rising dominance in market share; large POs have experience taking on risk, and many are moving toward global capitation; some hospitals have experience taking on more risk, and others are laying the groundwork to do so; and purchasers and consumers are more willing to accept limited networks and HMO gatekeeping in return for lower costs. However, the future of ACOs in California and the rest of the country is uncertain.

Long-range sustainability is a significant unknown about ACOs and remains a major barrier to their expansion. California ACO products are structured to address some of the issues around long-run sustainability. For example, they are based on limited-network designs with incentives for enrollees to choose lower-price providers. In some cases, providers are taking on more risk, although many of the underlying payment methods continue to be fee-for-service. Much work will be needed to refine and implement payment mechanisms, whether by more accurately capturing the value of additional care management in per-member, per-month fees paid to PPO-ACO providers or by moving toward global capitation for all ACOs.

Even with such payment refinements, however, ACO arrangements will still be challenging and costly to implement. In large part this is because, even in California, where gatekeeping HMOs and the delegated model have helped keep spending trends lower than in the rest of the country, providers still have a long way to go to manage spending across the care continuum.²³ Even aligned POs and hospitals are not that clinically integrated, especially when looking across all payers. Clearly, new limited-network ACO products are likely to take root only in markets where there is enough competition from Kaiser and other providers to spur innovation, and where there is at least one relatively lower-price, respected provider with enough service scope and geographic breadth to serve the market.

The establishment and longer-run viability of limited-network ACOs in these markets is likely to be heavily influenced by the experience of the first commercial and Medicare ACOs in reducing the spending trend over time. Not all fledgling ACO partners will be willing to wait: Two IPAs recently exited the Medicare Pioneer ACO initiative after only one year, and while the CalPERS HMO-ACO reported impressive initial savings, market observers question whether the savings rate will be sustainable.²⁴ It will be more challenging to generate long-term savings under PPO-ACOs, which do not have gatekeeping to limit self-referrals and to

direct care to lower-price providers. However, given that this population has not been managed at all, there may be some opportunities for at least one-time savings.

Limited-network ACO initiatives may have more potential outside of California because there may be more opportunities for efficiency. But in many markets, the costs and time to create the necessary infrastructure will be greater than in California. Also, in areas of the country without the same competitive and structural forces in place, employers may be unwilling to purchase limited-network products, especially HMOs that restrict patient choice of providers and patient self-referrals. However, employer and consumer experience with and willingness to accept limitations on provider choice and access could change if the limited-network products that insurers are developing to offer on state health insurance exchanges are successful. These exchange products themselves are not ACO products, though, and in most cases, insurers appear to be unilaterally selecting networks based on unit prices rather than collaborating with providers on reducing the total cost of care.²⁵

Outside of California, hospital acquisition of physician practices is another wildcard in terms of commercial ACO development. It could lead to better clinical integration, or it could create obstacles to effectively implementing ACOs if systems are able to exercise increased market leverage. Commercial ACO initiatives are underway in many markets around the country, and the proliferation of different models being tested in different market conditions will likely yield important insights into delivery system redesign.

Regional Markets Study

With support from the California HealthCare Foundation, researchers from the Center for Studying Health System Change (HSC) conducted interviews between November 2011 and April 2012 with health care leaders in six California regions to study these local health care systems. The work updated a similar study conducted in 2008. The six regions — Fresno, Los Angeles, Riverside/San Bernardino, Sacramento, San Diego, and the San Francisco Bay Area — reflect a range of economic, demographic, health care delivery, and financing conditions in California. Although the Sacramento, Bay Area, and Fresno regions each encompassed several counties, the interviews were largely concentrated in the largest, urban cores of these regions: Alameda County and the city and county of San Francisco for the Bay Area, and Sacramento and Fresno Counties. HSC researchers interviewed 185 people, including 167 community-level provider respondents (executives from hospitals, physician organizations, community clinics, and programs for low-income people), as well as 18 health plan executives and other state-level respondents. Researchers supplemented the qualitative interview information with quantitative data on demographics, provider characteristics, and other background information.

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California Health Care Almanac is an online clearinghouse for key data and analysis examining the state’s health care system. For more information, go to www.chcf.org/almanac.

ENDNOTES

1. For a regularly updated list of commercial and Medicare ACOs in California, see *ACO Activities in California*, Cattaneo & Stroud Inc., www.cattaneostroud.com. For a comparison of ACO development by state, see David Muhlestein et al., *Growth and Dispersion of Accountable Care Organizations: June 2012 Update* (Salt Lake City, Utah: Leavitt Partners, June 2012). Since there is no standard definition of ACO initiatives, counts and lists vary by source.
2. See the following for more detail on selected national ACO efforts: Bridget K. Larson et al., “Insights from Transformations Under Way at Four Brookings-Dartmouth Accountable Care Organization Pilot Sites,” *Health Affairs* 31, no. 11 (November 2012); Aparna Higgins et al., “Early Lessons from Accountable Care Models in the Private Sector: Partnerships Between Health Plans and Providers,” *Health Affairs* 30, no. 9 (September 2011).
3. More recently, California insurers have launched some smaller-scale ACO efforts which, like ACOs elsewhere, layer new payment arrangements on existing insurance products, but these more recent efforts are not the focus of this study.
4. For a more detailed discussion of ACOs, see Robert A. Berenson and Rachel A. Burton, *Accountable Care Organizations in Medicare and the Private Sector: A Status Update* (Washington, DC: Urban Institute, November 2011).
5. For example, in 2012, 55% of California workers with employer-sponsored insurance were enrolled in HMOs compared to 16% of covered workers nationwide. For more detail on enrollment by product line, see *California Employer Health Benefits Survey: Fewer Covered, More Cost*, NORC at the University of Chicago and California HealthCare Foundation (April 2013), www.chcf.org.
6. Market share data reflect commercial HMO insurance purchased individually and through the workplace. See *Overview of HMO Lives in California Comparing March 2011 to 2012 (revised November 2012)*, Cattaneo & Stroud Inc., accessed June 17, 2013, www.cattaneostroud.com.
7. Looking across total commercial enrollment in all products (HMOs, PPOs, etc.), Kaiser has a 40% market share. The next three largest commercial insurers — Anthem, Blue Shield, and Health Net — have a combined market share of 43%. Anthem is the dominant insurer in the PPO market. For more detail, see Katherine Wilson, *California Health Plans and Insurers: A Shifting Landscape*, California HealthCare Foundation (March 2013), www.chcf.org.
8. While IPAs are paid capitation by HMOs, the IPA may pay member physicians fee-for-service, with incentives for quality and efficiency, or subcapitation. Because of federal antitrust regulations, IPAs are only permitted to negotiate on behalf of independent physicians for risk-based insurance contracts, like HMOs, and not fee-for-service contracts, like PPOs. A limited number of IPAs nationwide, including Brown & Toland Physicians in the Bay Area, received Federal Trade Commission (FTC) approval to negotiate PPO rates because they meet the FTC’s criteria for clinical integration.
9. Because California’s corporate practice of medicine laws prohibit hospitals from directly employing physicians, one way that hospitals can align with physicians is to sponsor medical foundations. Under a medical foundation model, physicians either contract with the foundation through an affiliated IPA or are part of a medical group that contracts exclusively with the foundation through a professional services agreement. The foundation, in turn, contracts with health insurers. However, some of California’s largest IPAs continue to contract directly with HMOs but still align to varying degrees with hospitals through other means, for example, close referral relationships (e.g., Hill Physicians with Dignity Health, Brown & Toland with Sutter Health, and Sharp Community Medical Group with Sharp HealthCare). HealthCare Partners has taken a different approach of holding HMO global capitation contracts itself and then directly paying hospitals.
10. For more on the history of capitation in California, see Eric Hammelman et al., *Reforming Physician Payments*, California HealthCare Foundation (September 2009), www.chcf.org. Hospital utilization metrics are included in HMO pay-for-performance programs in California, but they do not have substantial financial impact on POs.
11. Robert B. Berenson, Paul B. Ginsburg, and Nicole Kemper, “Unchecked Provider Clout in California Foreshadows Challenges to Health Reform,” *Health Affairs* 29, no. 4 (April 2010) and Jon B. Christianson, Ha T. Tu, and Genna R. Cohen, *Managed Care in California: Cost Concerns Influence Product Design*, California HealthCare Foundation (December 2009), www.chcf.org.
12. Christianson, Tu, and Cohen, *Managed Care*.
13. See NORC and CHCF, *Health Benefit Survey*; Wilson, *California Health Plans*; and *California Health Plans and Insurers*, California HealthCare Foundation (October 2010), www.chcf.org.
14. PO HMO risk-bearing is regulated in California; whether and how HMO-ACOs and PPO-ACOs will be regulated at the state or federal level is still evolving. For example, while Sharp Health’s affiliated IPA may not negotiate PPO fees for its member physicians under antitrust regulations, it is negotiating rates for the PPO-ACOs. For more background on California ACO regulatory issues, see James C. Robinson and Emma L. Dolan, *Accountable Care Organizations in California: Lessons for the National Debate on Delivery System Reform* (Oakland, CA: Integrated Healthcare Association, 2010).

15. See regional markets issue briefs on the California HealthCare Foundation website for more detail on ACO activity in each market.
16. Some national insurers appear willing to accept a much lower threshold of covered lives in an ACO experiment. (See Table 1.) Aetna's PPO-ACO in San Diego, for example, has enrollment under 3,000. This lower threshold may reflect differences in product design among insurers. Also, Aetna, Cigna, and other national insurers that are rolling out many ACOs across the country may be better able to spread fixed development costs over more markets or have more capital to invest in the effort.
17. See, for example, Paul Markovich, "A Global Budget Pilot Project Among Provider Partners and Blue Shield of California Led to Savings in First Two Years," *Health Affairs* 31, no. 9 (September 2010) and *An Accountable Care Organization Pilot: Lessons Learned*, Blue Shield of California (2012), www.blueshieldca.com.
18. See, for example, Steve Davis and Roberta Sniderman, "How Models Work: Care Coordination from an IT Perspective" (paper presented at the HIMSS Annual Conference and Exhibition, Las Vegas, Nevada, February 2012).
19. Jeff Goldsmith, "Accountable Care Organizations: The Case For Flexible Partnerships Between Health Plans And Providers," *Health Affairs* 30, no. 1 (January 2011) and James C. Robinson, *Accountable Care Organization for PPO Patients: Challenge and Opportunity in California* (Oakland, CA: Integrated Healthcare Association, 2011).
20. Robinson, *Accountable Care Organization*.
21. Markovich, "Global Budget Pilot Project."
22. Paul B. Ginsburg, "Achieving Health Care Cost Containment Through Provider Payment Reform That Engages Patients and Providers," *Health Affairs* 32, no. 5 (May 2013).
23. Anne B. Martin et al., "Health Spending by State of Residence, 1991–2004," *Health Affairs* 26, no. 6 (September 2007) and Richard M. Scheffler and Liora G. Bowers, *A New Vision for California's Healthcare System, Appendix XII: Assessing California's Healthcare Spending* (Berkeley, CA: Berkeley Forum for Improving California's Healthcare Delivery System, February 2013).
24. Despite Blue Shield's HMO-ACO effort, CalPERS recently decided to expand its HMO offerings beyond Blue Shield and Kaiser starting in 2014. It was also recently reported that Kaiser's HMO premiums for CalPERS in 2014 will surpass both Blue Shield's HMO premium and Anthem's PPO premium. See "CalPERS Picks Four New HMO Plans for 5-Year Contracts," *Los Angeles Times*, April 17, 2013, and "Kaiser's Rising Premiums Spark Employer Backlash," *Los Angeles Times*, July 24, 2013.
25. Steve Davis, "Blues Increasingly Turn to Tiered Networks to Compete in Transparent 2014 Market," *AIS Health Business Daily*, April 23, 2013.