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Many Routes to the Top: Efforts to Improve Care Quality, Coordination, and Costs Through Provider Collaborations

In response to the federal Patient Protection and Affordable Care Act of 2010 (ACA) and a combination of broader market forces, hospitals, physicians, and other health care providers around the country have been increasingly collaborating among themselves and with public and private payers on efforts to reform care delivery systems and payment methods. While their structures vary widely, most of these initiatives share the overarching aims of slowing the growth of health care spending and improving the coordination and quality of patient care.

California providers have been particularly active in developing collaborations with other providers and with commercial health plans. Many of these provider partnerships have been driven in part by key market factors characteristic of many California communities — most notably the presence of large providers experienced in managing financial risk for patient care, as well as competitive pressure on both insurers and providers from the growing dominance of Kaiser Permanente's integrated delivery system and health plan.

The California Health Care Foundation's longitudinal Regional Markets Study of seven California health care markets provided a unique opportunity to track the development of collaborative relationships that hospital and physician organizations have formed in the state over the past several years. This paper describes major types of provider collaborations that have proliferated in California since 2013, highlights leading examples from the seven regions studied, discusses providers' key goals and strategies, and explores how market conditions spurred each major type of partnership and influenced their structure. The analysis also considers some of the key effects that these collaborations might have on cost, quality, and access to care in local health care markets. The intent of the paper is not to provide an exhaustive catalog of all collaborations undertaken by providers; instead, the focus is on those initiatives highlighted by hospital and physician executives, as well as market observers, as particularly important to the overall strategies and objectives of provider organizations.

The focus of this paper is on collaborations formed by mainstream health care providers — those that serve large populations of commercial and Medicare patients.

Integrating Care: Provider Collaborations to Form Region-Wide Integrated Care Networks

An increase in efforts by major providers — primarily hospital systems — to pursue population health strategies represents one of the most significant developments in several major California health care markets over the past few years. In response to policy changes and market forces that are moving both public and private payment away from fee-for-service toward value-based models that reward efficiency, providers are seeking to transform themselves into region-wide integrated systems of care. While these efforts vary widely in structure and organization, they share the common aim of building a care network that is broad and attractive enough to

purchasers and consumers to compete vigorously for sizable populations of well-insured patients while also achieving enough efficiency in managing patient care that providers can fare well financially in competition against the likes of Kaiser Permanente.

Not surprisingly, most of these efforts to develop region-wide population health strategies are taking place in major metropolitan markets with large populations of well-insured patients. In Northern California, these markets include the San Francisco Bay Area and Sacramento; in the southern part of the state, Los Angeles, Orange, and San Diego Counties all are seeing active efforts to develop integrated care networks. These are also markets that have large, financially strong hospital systems capable of making the capital investments in such ambitious initiatives. Many of these systems have long thrived as high-priced providers exercising strong leverage against commercial payers in a fee-for-service environment and still have a large proportion of their payments under lucrative volume-based arrangements. However, as one market observer noted, "Large systems [are] taking major, proactive steps to try to transform themselves into high-value regional systems of care . . . while [financial] margins are still strong . . . so they don't get left behind by a changing market."

Another key characteristic common to these markets is the strong and growing presence of Kaiser, whose HMO products emphasizing moderate premiums and out-of-pocket costs, combined with seamless access to services (especially primary care), has put pressure on competing providers and insurers to offer similar combinations of value and access.

Some large systems — most notably Sutter Health in Northern California and Sharp Healthcare San Diego — have sufficient breadth of services and geographic coverage to pursue regional population health strategies on their own, but a number of other prominent systems instead have chosen to team up with other systems in their own regions to build integrated, region-wide networks together. Systems that are taking a collaborative approach to their pursuit of population health are often those with a strong, even dominant, presence within a particular submarket but a more limited presence in the larger region. By aligning with one or more providers based elsewhere in the same region, systems are seeking to expand their clinical footprint to compete for patients over a significantly broader geographic area.

In seeking strategic partners for building a region-wide network, systems also have been seeking partners that possess complementary strengths, so that the combined entity can better compete for patients by offering a full range of clinical services efficiently across the region. For example, academic medical centers focused on high-end tertiary services tend to join forces with systems that have expertise in building physician networks (particularly of primary care physicians) and managing patient care — typically an area of relative weakness for AMCs.

Among the seven markets in this study, Orange County was particularly active in developing such population health collaborations. Two of the region's major systems, St. Joseph Health System and Hoag Health, embarked on a joint venture in 2013, forming a new operating company called St. Joseph Hoag Health (SJHH) to develop a system of care and work toward population health management. The two systems entered into a joint operating agreement — a "virtual merger" that aligned the two systems very closely but did not merge their assets.[1,2] This arrangement gave St. Joseph access to the very affluent coastal region, where Hoag has long been dominant, as well as to Hoag's well-known surgical specialty hospital in Irvine, a large, well-insured population center. The partnership reportedly gave Hoag an opportunity to diversify beyond its limited geographic base and its historic focus on high-cost specialty services by opening up access to St. Joseph's broad primary care base. In aligning with St. Joseph's, Hoag also sought to leverage the latter's foundation model to help launch Hoag's first medical group.

Also in 2013, another of Orange County's major providers, MemorialCare Health System, developed a partnership with the county's only academic medical center, UC Irvine Health. This affiliation represented the expansion of a

decades-old relationship between the two organizations surrounding teaching programs. Unlike St. Joseph and Hoag, MemorialCare and UC Irvine continue to operate as two independent entities. However, the partnership does share with SJHH the same overall goal of establishing a broader geographic network of integrated care delivery. Under the arrangement, MemorialCare supplies its primary care expertise while UC Irvine provides more specialty and tertiary services, backed by its 500-strong faculty practice.

One of the ways these Orange County partnerships are seeking to compete for commercial patients is by introducing new models for sharing risk with employers. Recently, SJHH and MemorialCare separately created tiered-network products for self-insured employers. Under these arrangements, the provider and employer jointly set a spending target for total cost of care for the employer's total covered lives, and share in savings or losses. While these arrangements are still quite new, with relatively low enrollment to date, in mid-2016 the MemorialCare Health Alliance (which includes not only MemorialCare and UC Irvine but also Torrance Memorial Health System and PIH Health) won a direct contract with large national employer Boeing. Under the arrangement, a new HMO product whose provider network consists of the MemorialCare Health Alliance partners will be offered to Boeing's Southern California employees, who are concentrated in Orange County and the adjacent Long Beach / South Bay areas of Los Angeles County. The new product is being offered to Boeing's employees and dependents in the region alongside existing options such as a Kaiser HMO.[3] Coverage is slated to begin in January 2017 for the new product, which offers incentives to enroll such as low premiums, zero out-of-pocket costs for primary care visits and generic drugs (after the deductible has been met), and increased Boeing contributions to health savings accounts for eligible employees.[4]

The San Francisco Bay Area — a region historically characterized by many segmented, distinct submarkets — also saw two of its key providers collaborating to build a region-wide integrated care network. In early 2015, the University of California, San Francisco Medical Center (now part of UCSF Health) formed a strategic partnership with John Muir Health, a system with a dominant presence in the East Bay's Contra Costa County. Initially known as the Bay Area Accountable Care Network, and recently renamed Canopy Health, the partnership aims to build a region-wide integrated network to compete with Kaiser and Sutter for commercial patients. UCSF and Muir also set up a separate but related development company, Bay Health, to build new ambulatory facilities and to integrate their clinical IT systems. Adding ambulatory capacity in submarkets such as North Oakland and Berkeley would allow Canopy Health to better compete for patients against Kaiser and Sutter — the two providers that have historically dominated that well-insured submarket. As with the Orange County collaborations, Muir and UCSF bring complementary strengths to their partnership: Muir's strong track record of building physician networks and managing care, and UCSF's substantial footprint and status as a premier destination for highly specialized services.

In mid-2016, it was announced that three IPAs (Hill Physicians Medical Group, Muir Medical Group IPA, and Meritage Medical Network) had joined Canopy's two founding hospital partners as both shareholders and participating providers.[5] Canopy Health also added seven hospitals to its network, including five in the East Bay and two in the North Bay.[6] Pending final state approval of a restricted insurance license, Canopy Health is expected to partner with health plans to offer HMO products to mid-sized and large groups. Open enrollment would begin in the fall of 2016 for coverage starting in 2017. One health plan contract already in place is an agreement between Health Net and Canopy Health for the latter to assume financial risk for about 13,000 University of California employees and dependents already covered by Health Net's HMO product.[7]

In Los Angeles and neighboring Orange County, a high-profile collaboration known as Vivity brought together one of California's largest commercial health plans, Anthem Blue

Cross, and seven health care systems — including renowned institutions such as Cedars-Sinai Medical Center and UCLA Health.[8] As one participant described it, Vivity's "uniqueness and novel nature . . . [stems from] the experiment of teaming up seven systems that previously competed quite strongly against each other, and still do compete outside of Vivity, and working to create one integrated entity . . . [that delivers] seamless and cost-efficient care." Each of the eight partners shares equal risk in the joint venture, which was announced in 2014 and began offering HMO products to select large groups in 2015. The most prominent of those groups was the California Public Employees' Retirement System (CalPERS), the state's largest purchaser of health benefits. In its first year, Vivity made very modest inroads in the CalPERS market, capturing just 1% of CalPERS members in the region.[9] However, Vivity's total enrollment of 24,000 in its first year of business, across all its large groups, exceeded its initial first-year projection of 15,000 enrollees.

Like other collaborations aimed at forming integrated systems of care, Vivity focuses on offering HMO products whose efficiency, as well as convenience and access for patients, can rival or surpass those of Kaiser. To achieve efficiency, Vivity is pursuing clinical integration aggressively, but is still in the early stages of pooling and integrating all the participants' clinical data — a task that one participant described as a "Herculean effort . . . with costs and challenges to match." The initiative also has a long way to go in attaining its eventual objective of creating a system of seamless referrals that would allow physicians to identify which providers within the broad network offer the best-in-class options for a given service and refer patients to those providers. As one market observer noted, "That's not only a big challenge from a clinical data standpoint . . . [but] it's a major paradigm shift for all these hospitals. . . . It remains to be seen whether docs [aligned with] hospital A will actually refer patients away from their own hospital and steer them to hospitals B, C, and D instead . . . if those [offer] higher value for, say, a hip replacement. It's a tall order, but that's what Vivity has to achieve if they're going to be cost-competitive in the long run."

Such challenges are not unique to Vivity. Indeed, they confront each of the initiatives seeking to transform providers rooted in conventional fee-for-service payment into integrated delivery systems prioritizing efficiency and value. This paradigm shift needs to occur both within each provider organization and across all providers within a collaboration, as pointed out by both providers and market observers. Within each provider organization, incentives and culture need to be shifted away from longstanding fee-for-service strategies under which many have thrived. How much, and how fast, to pivot away from these approaches is a debate of interest to all large systems pursuing population health strategies, whether they're doing so largely on their own, like Sutter Health in Northern California and Scripps Health in San Diego, or are doing so through major collaborations. (An exception is Scripps' major competitor, Sharp Healthcare, which has long embraced capitation and positioned itself as a reasonably priced, high-value provider in the San Diego market.)[10]

For providers collaborating with others in pursuit of an integrated network, these challenges are compounded by the need to balance potentially conflicting cultures, interests, and incentives across all the partners. As one participant in such a collaboration observed, "One of the biggest challenges we face in making [the collaboration] work is the reality that we're not one organization; we're separate organizations, with separate boards of directors [and] governance structures." This respondent also highlighted another key challenge: "The providers we're partnering with are our direct competitors [outside the collaboration], so we recognize we might, to a certain extent, be cannibalizing our own business in pursuing [this collaboration]." However, participation in joint ventures also has stimulated dialogue among partnering providers, leading to the opportunity for some new collaborations.

Several providers and observers pointed to yet another challenge faced by these partnerships: the fundamental trade-off that exists between provider network breadth on the one

hand, and the degree of care integration, coordination, and efficiency that can be achieved on the other. Although building a broad network composed of many provider partners may help achieve "greater access and convenience for consumers and better marketability [of the related insurance products], it amplifies the challenges of creating a single unified, high-value delivery system," as one hospital executive noted.

Reducing the Total Cost of Care:
Commercial ACO Collaborations Between Providers and Health Plans

In the last round of this study in 2011-12, a few large California providers had begun collaborating with major health plans to form commercial accountable care organizations (ACOs). These partnerships aim to better compete for commercial business by collaborating to control total health care costs, which in turn helps keep insurance premium increases in check. While commercial ACOs share some key objectives with the population health collaborations described above, they generally expose providers to far less financial risk for patient care and do not require the same level of system transformation.

California's first commercial ACO was launched in the Sacramento market as a 2010 pilot by Blue Shield and its provider partners — Dignity Health, a hospital system, and Hill Physicians, an IPA — in an effort to reduce premium trends in Blue Shield's HMO product for the state's largest purchaser, CalPERS. The arrangement, under which the three partners shared both upside and downside risk for the total cost of care, was successful enough in generating savings that Blue Shield soon expanded it to other purchasers and other regions, including the 2011 launch of two ACOs for the San Francisco Health Service System, which purchases benefits for employees of the City and County of San Francisco. Over the past few years, Blue Shield's ACO collaborations have expanded to include a growing number of provider partners as part of the health plan's Trio ACO HMO network, which is now offered to both large and small groups across many California markets.[11]

Along with Sacramento, San Diego was one of the first markets to see health plans and providers experimenting with commercial ACO collaborations. The Anthem Blue Cross ACO, introduced as a pilot in 2011, launched full-fledged commercial products in 2012. Anthem's first provider partners were Sharp Healthcare's physician organizations: Sharp Community Medical Group (Sharp's closely affiliated IPA) and Sharp Rees-Stealy (Sharp's multispecialty medical group). In contrast to Blue Shield, Anthem Blue Cross based its ACO on a PPO platform, attributing patients to primary care physicians (PCPs) based on past utilization patterns. Like most ACO PPO arrangements in other markets nationwide, PCPs continued to be paid on a fee-for-service basis but also received per-member, per-month care management fees for their attributed patients and were eligible to participate in a shared-savings pool.

In the years since those early ACO collaborations, the major national insurers Aetna, Cigna, and United Healthcare all have formed their own ACO collaborations with providers. Like Anthem, these insurers all based their ACOs on PPO platforms and share similar approaches to key program features such as patient attribution, care management fees, and shared savings, though the specifics of their methodologies differ. All ACOs — including Blue Shield's ACO HMO model — emphasize the exchange of data between health plan and providers as a critical part of managing patient care more efficiently.

By 2015, commercial ACOs had spread to all seven of the California regions in this study. Even Fresno, which historically has lagged behind other health care markets, saw the launch of its first commercial ACO when Santé Community Physicians, the market's largest IPA, began partnering with Anthem Blue Cross. Not surprisingly, in large markets where major providers have a long track record of successfully assuming financial risk for managing patient care, some large physician organizations participate in ACOs with multiple

health plans. In San Diego, for example, Sharp-Rees-Stealy and Sharp Community Medical Group currently take part in ACOs with Aetna, Anthem Blue Cross, and United. In the Bay Area, Brown & Toland Physicians, a large IPA, participates in ACOs with four health plans: Aetna, Anthem Blue Cross, Blue Shield, and Cigna.

Despite their growing participation in commercial ACOs, several large providers expressed reservations and frustrations about these initiatives. Some noted that sharing risk with health plans in ACOs is less advanced from a provider standpoint than accepting full risk under capitation — an arrangement that gives them much greater control over patient care. "In some ways, [ACOs] represent a frustrating step backward compared to our capitated business . . . where we've already built a strong infrastructure to manage care," an executive of a large physician organization commented. A fundamental limitation of the shared-savings approach common to ACOs is that it requires the partners to continue identifying new sources of savings over time in order to keep earning shared savings, after the "savings have already been wrung out of the low-hanging fruit" early in the initiative, as one health plan executive noted. This stands in contrast to capitation, which allows providers to be rewarded consistently from one contract to the next as long as they continue to manage care efficiently.

In addition, providers and health plans noted the many data and logistical challenges of ACO collaborations. While data-sharing between providers and health plans has progressed significantly since the earliest days of ACOs, the patient data currently available to providers for ACO lives are still not nearly as timely or comprehensive as the data that providers have for their capitated patients, according to several providers. Care management represents another key logistical challenge for ACOs, with health plans and providers often treading on each other's toes with separate programs whose lack of coordination not only reduces efficiency for the ACO partners, but also can lead to confusion and frustration for patients.

Despite these challenges, providers across most markets continue to explore ways to expand their ACO collaborations. As commercial capitation continues to erode slowly in most markets, participation in ACO PPOs is widely seen as a way for providers to increase (or at least maintain) their patient volumes. As one San Diego physician executive observed, "However clunky [ACOs] are . . . they allow us to reach people who have never been in, and will never be in, HMOs. . . . It gives us a chance to capture people who might not [otherwise] be our patients."

Consolidating Services:
Clinical Affiliations Between Hospitals

Clinical affiliations between hospitals have long been common, with the most typical partnerships being those between a large system or academic medical center and a smaller community hospital. These partnerships serve multiple objectives, ranging from traditional fee-for-service strategies to newer population health approaches that many hospitals have begun to pursue in recent years. A longstanding and still critical motivation for clinical affiliations has always been to drive tertiary and other specialty referrals to the large system or AMC. The affiliation also expands the range of clinical expertise available to the community hospital, thus potentially enhancing its brand and increasing its patient volume. In addition to increasing mutually beneficial referrals, these affiliations can enhance efficiency by directing care to the most appropriate setting — keeping routine secondary care in community hospitals (which may also increase convenience and access for patients) while allowing the AMC or other large tertiary hospital to focus on more highly specialized services. In recent years, this has become a more central focus as large systems increasingly pursue population health strategies, as described above. As a result, their existing affiliations with community hospitals have tightened, as the systems seek to incorporate these smaller hospitals into new region-wide clinically integrated networks. Large systems also have been forming new

affiliations with more community hospitals, both within and beyond their immediate geographic markets.

San Diego is among the markets to experience a recent surge in clinical affiliations. In 2015, UC San Diego Health (UCSD) announced an affiliation with Tri-City Medical Center, a district hospital that had struggled in recent years to compete against larger rivals encroaching on its geographic service area. In addition, UCSD and Scripps both reached beyond the boundaries of San Diego County to form affiliations with district hospitals in neighboring Imperial County — and in UCSD's case, with a hospital in Riverside County as well.

In the Los Angeles market, UCLA has been particularly active in expanding its partnerships with community hospitals. In large part, these affiliations are intended to relieve capacity constraints at UCLA's flagship, Ronald Reagan UCLA Medical Center, which has been consistently operating at or near full capacity. Developing a full network of affiliated community hospitals to which more routine inpatient care can be directed allows Reagan to focus on the tertiary and quaternary services for which it is widely known, and allocates resources more efficiently across inpatient settings — a key consideration as the UCLA system prepares to take on greater financial risk for more patients. By the fall of 2016, the number of community hospitals affiliating with UCLA will have risen to 10. UCLA has established hospitalist programs in each of these affiliated hospitals to oversee care for its own patients.

In the Bay Area, numerous affiliations formed in the past few years, including Muir's joint venture with San Ramon Regional Medical Center and UCSF's partnerships with Washington Hospital Healthcare System in Alameda County and Marin General Hospital in Marin County. These affiliated hospitals were recently announced as participating providers in the Canopy Health network led by UCSF and Muir.

In addition to these affiliations, the Bay Area also saw some hospital acquisitions, including deep-pocketed Stanford Health Care and UCSF each acquiring an East Bay hospital. Across the markets in this study, however, there were few recent instances of large hospitals acquiring smaller ones. Instead, most hospital systems have been pursuing an array of different affiliations that expose their organizations to far lower costs and fewer risks — and less regulatory scrutiny — than outright acquisitions. Respondents pointed to the need for all inpatient facilities to meet stringent state seismic standards as a particular deterrent to hospital acquisitions. More broadly, respondents agreed that the continuing decline in inpatient use over time — the result of advances in medical technology as well as changes in payment incentives — makes inpatient facilities less attractive as acquisition targets.

A particular type of clinical affiliation that has gained prominence in recent years is a partnership between a pediatric hospital and another hospital in the same region — either a large hospital focusing on adult medicine, or a smaller community hospital. Given the limited size of the market for inpatient and specialty pediatrics, this collaborative approach helps avoid needless duplication of pediatric services. These collaborations allow the pediatric hospital to expand its geographic reach while keeping costly capital investments in check, and gives partnering hospitals access to a prestigious pediatric brand and specialized pediatric expertise. By making pediatric specialists and services available at more locations throughout a region, these partnerships can also improve convenience and access for patients.

The most prominent examples of these affiliations come from the Bay Area, where highly regarded pediatric hospitals at both Stanford and UCSF expanded their geographic reach through multiple partnerships. Stanford Children's Health (Lucile Packard Children's Hospital) developed separate partnerships with Sutter's California Pacific Medical Center and John Muir Health, allowing pediatric patients to be seen by Packard specialists in both San Francisco and Contra Costa Counties. In 2015, Muir and Packard jointly launched a pediatric intensive care unit at Muir's Walnut Creek flagship hospital. Meanwhile, UCSF extended its reach into the North Bay by partnering with Marin General and Santa Rosa

hospitals as well as expanding into the East Bay by acquiring Children's Hospital Oakland.

Preventing Unnecessary Hospital Use: Collaborations Between Hospital Systems and Social Service / Safety-Net Providers

In common with hospitals nationwide, California hospitals have become more focused on reducing preventable readmissions since the Centers for Medicare and Medicaid Services (CMS) began levying financial penalties for excessive Medicare readmissions in 2012. In San Diego, four of the county's five largest hospital systems (Palomar Health, Scripps, Sharp, and UCSD) joined forces with the county government in an initiative known as the San Diego Care Transitions Partnership, aimed at reducing readmissions for high-risk Medicare patients discharged from hospitals into the community. Part of a nationwide CMS demonstration project, the San Diego program has proved successful at reducing readmissions and costs for CMS since its 2013 launch.

Although CMS is likely discontinuing the program nationwide in late 2016 to focus on other payment reforms, the local participants in the San Diego collaboration reportedly plan to continue some of the program's most effective interventions. These include a bundle of "care enhancement" social services provided by the county to a subset of frail patients deemed most at risk for readmissions, with funding to be provided by the four systems to replace discontinued CMS funding. One hospital executive observed that, before the collaboration, most hospitals had not been aware of how cost-effective the targeted provision of social services could be in reducing readmissions and other costly outcomes.

California hospitals also have paid increasing attention to preventing avoidable hospital utilization by Medi-Cal and other low-income patients. Since the beginning of 2014, when the ACA provision to expand Medicaid eligibility took effect, hospitals in most communities experienced surges in the use of their emergency departments (EDs) by newly insured Medi-Cal enrollees. This increased demand led to serious ED capacity constraints in some communities. In response, hospitals have stepped up collaborations with safety-net providers in an effort to reduce avoidable use of EDs and other hospital services and to connect low-income patients with a medical home that can provide them with the primary and urgent care for which many people seek ED treatment. Typically, hospitals collaborate with Federally Qualified Health Centers (FQHCs) — community health centers that receive federal grants and enhanced, cost-based payments for serving Medi-Cal patients. While hospital-FQHC collaborations can take many forms, one common arrangement has been for a hospital to provide an FQHC funding to establish a clinic site, or expand capacity of an existing clinic site, on or near the hospital campus.

Competing on Price, Access, and Convenience: Collaborations by Hospital Systems to Expand Ambulatory Care

Consistent with trends seen across the country, hospital systems in California have expanded their presence in a wide variety of ambulatory settings. These ambulatory expansions include the development of physician networks through many outright acquisitions of independent practices, as well as various affiliations with physician organizations. Systems also have been very active in adding a wide variety of ambulatory facilities to their networks, ranging from convenience clinics to ambulatory surgery centers and imaging centers — often in collaboration with a variety of other organizations. Two types of ambulatory facilities where providers have engaged in the most collaborative activity are highlighted here.

Convenience/retail clinics. Hospital systems in multiple California markets have launched several forms of convenience care — most notably health clinics located in retail stores. Most of these clinics, typically staffed by nurse practitioners, provide basic preventive services and treat uncomplicated minor conditions on a walk-in basis, often with extended hours. For consumers, these clinics offer the potential to increase access, convenience, price transparency,

and low-cost options for a basic set of primary and preventive services. For providers, the clinics can offer a way of boosting visibility for their brands in the community and gaining new patients, as well as expanding convenient options for existing patients.

The growth of convenience clinics has been most pronounced in San Diego, where most of the major systems have formed partnerships to operate clinics at busy retail locations. Since 2008, Palomar Health has partnered with the Albertsons grocery and pharmacy chain to run clinics located in Albertsons stores, but the retail clinic phenomenon gained real traction only over the past few years. San Diego's largest system, Sharp, began partnering with CVS/MinuteClinic in 2013, followed by Kaiser affiliating with Target in 2014. Within the past year, Scripps launched its first convenience clinic, taking a somewhat different approach: partnering with a commercial real estate firm, The Irvine Company, to open a health clinic in an office tower near a large shopping mall. In addition to the usual set of convenience care services, the new clinic partners with employers to offer wellness services. The Irvine Company's partnership with Scripps is similar to affiliations the company has formed with other prominent providers in the state, including St. Joseph Hoag Health in Orange County and Stanford Health in Santa Clara.[12] In the past year, the number of California providers partnering with CVS/MinuteClinic has expanded to include Sutter and Muir in Northern California.[13]

Freestanding ambulatory facilities. Hospital systems increasingly have been bringing more freestanding facilities such as ambulatory surgery centers (ASCs) and imaging centers into their networks, with some transactions structured as joint ventures and others as outright acquisitions. These freestanding facilities have long provided services at substantially lower prices than either hospital inpatient or outpatient departments. Under the traditional fee-for-service payment methods that prevailed in past decades, it was a common strategy for hospitals to acquire these facilities and then promptly absorb them into hospital outpatient departments, thus increasing the number of ambulatory sites that could charge higher outpatient-department unit prices to both commercial payers and Medicare.

Over the past several years, however, hospitals' primary motivations and strategies for bringing these freestanding facilities into their own networks have undergone a dramatic reversal. As hospitals have come under pressure to compete on value, the attribute of freestanding facilities that now appeals the most to hospitals is their low cost structure. As a result, hospitals are "focused on keeping the facilities they acquire [or affiliate with] staffed and operating as before, to maintain cost-efficiency. . . . It's quite a turnaround from what we saw hospitals doing 10, 15, 20 years ago," commented a market observer.

This approach of adding low-cost ambulatory facilities to their networks helps hospital systems manage the cost of care for the growing number of patients for whom they are taking on varying degrees of financial risk, in arrangements varying from bundled payments to ACOs to provider-sponsored health plans. Having ambulatory facilities with a lower cost structure also helps systems better compete for the many privately insured patients covered by high-deductible health plans: patients who have strong incentives to minimize their own out-of-pocket costs by price-shopping and choosing a lower-priced provider over a hospital outpatient department. In addition, expanding the number of locations in the community where patients can receive services such as imaging tests or ambulatory surgeries helps the systems better compete on the basis of access and convenience.

Several of California's historically high-priced hospital systems have formed partnerships with freestanding facilities in the past few years. Sutter Health has been particularly active in this regard. The system not only has engaged in numerous joint ventures with physician-owned ASCs throughout its home base of Northern California, but is accumulating a growing network of ASCs in Southern California as well.[14] In the Los Angeles market, UCLA Health also is engaging in ASC joint ventures, partnering with a national company with

an established track record in operating freestanding surgical facilities. In San Diego, after Scripps Health acquired a chain of radiology centers in 2015, it kept the facilities' brand name (Imaging Healthcare Specialists) and operations unchanged, and continues to use the same independent radiologists who had staffed the facilities previously.

Supporting Continuity of Care:
Collaborations Between Acute Care Providers and Post-Acute Care Providers

Rehabilitation hospitals. Acute rehabilitation hospitals, also known as inpatient rehabilitation facilities, occupy a key space in the care continuum between acute care hospitals and post-acute providers such as skilled nursing facilities (SNFs). These facilities often are the most appropriate setting for many patients recovering from conditions such as major strokes, brain and spinal cord injuries, and joint replacements, who can be discharged from a tertiary setting but require more intensive rehabilitation and physician oversight than SNFs can provide. Because most communities lack sufficient acute rehab capacity, many patients who could be discharged to such facilities continue occupying beds in tertiary hospitals for longer periods, and at higher cost, than necessary, according to hospital executives.

To meet the dual goals of freeing up tertiary beds for sicker patients and providing more cost-efficient care for patients needing intensive rehab, major hospital systems are forming partnerships to create more acute rehab capacity. In Los Angeles, the two most prominent hospital systems, Cedars-Sinai Medical Center and UCLA Health, jointly collaborated with Select Medical, a national company specializing in long-term acute care and rehab services, to develop the California Rehabilitation Institute, a 138-bed facility that opened in 2016. Select Medical's reputation and track record of being able to operate acute rehab facilities efficiently is reported to have made the company an especially attractive partner for Cedars-Sinai and UCLA. Major hospitals in other California markets reportedly are exploring similar partnerships to expand acute rehab capacity.

Post-acute care providers. Some large providers — such as the physician organizations Healthcare Partners and Heritage Provider Network, both based in Southern California — have long taken full risk for sizable Medicare Advantage populations. As a result, they have focused on the efficiency and value of care provided along the entire care continuum, including post-acute care. Because Medicare Advantage plans — in contrast to Medicare fee-for-service providers — are permitted to limit their provider networks, providers accepting full risk can develop relationships with a subset of affiliated SNFs and other post-acute providers to whom they send their Medicare Advantage patients. These network providers are selected based on cost and quality metrics as well as geographic service areas. To oversee care for their Medicare Advantage patients in the post-acute setting, Healthcare Partners, Heritage, and other providers taking full risk also have long placed their own physicians and other clinicians in SNFs to oversee care for their patients. Care by these "SNFists" (also referred to as "post-acute hospitalists" by some organizations) often helps reduce SNF lengths of stay and prevent hospital readmissions, and improves the overall quality and frequency of clinical oversight for SNF patients.[15]

In contrast to Medicare Advantage plans, fee-for-service providers — even those subject to partial financial risk under Medicare ACOs or bundled payments — must allow Medicare patients the freedom to select the post-acute provider of their choice.[16] Hospitals and physician organizations accepting partial risk may develop networks of preferred SNFs for their patients, but the process is intended to guide, rather than dictate, patient choice of a SNF. Some fee-for-service providers use "soft steering" approaches such as describing to patients and their families the relative merits of preferred facilities (e.g., higher quality, better coordinated care), but ultimately, Medicare fee-for-service patients retain their right to choose any accredited facility, whether or not it is included in the preferred network.

Hospital systems and physician organizations expressed uncertainty and frustration at what they viewed as lack of clear CMS guidelines on the extent to which preferred networks and soft steering are permitted. Providers also pointed out that they are increasingly being exposed to more risk under Medicare payment reforms ranging from readmission penalties to bundled payment programs. As a result, several providers suggested that CMS change current rules to allow providers who are subject to partial financial risk to establish limited networks to steer Medicare fee-for-service patients to high-value SNFs and other post-acute providers — much in the way Medicare Advantage plans are already able to.

According to some providers, CMS rules do not pose the only barrier to developing effective SNF networks. Another key limitation stems from the limited pool of high-quality, low-cost SNFs that are available to serve as strong partners for acute care providers. "Here in Southern California, there are lots of skilled nursing beds — the sector is probably overbedded overall — but our problem is finding enough good facilities to partner with: the ones that are well managed . . . financially stable, have appropriate standards of clinical care, [and] are amenable to working with us on care protocols," a hospital executive said.

Hospital systems and large physician organizations have focused the most attention on relationships with SNFs — in large part because these facilities represent the largest share of post-acute spending — but acute care providers also have been forming or exploring affiliations with the full range of post-acute providers, including home health agencies and palliative care / hospice organizations. For example, in 2015 UCSF formed an affiliation with Hospice by the Bay aimed at expanding high-value care for seriously and terminally ill patients. Other large acute care providers expressed the need for their own organizations to form similar partnerships with providers along all parts of the care continuum if they are to be successful in increasingly taking on full or substantial financial risk for patients — as UCSF is slated to do in its Canopy Health venture.

Developing New Primary Care Practice Models: Collaborations Between IPAs and Other Organizations

Over the last few years, the physician sector saw the continuation of an ongoing trend: small, independent practices becoming a progressively less viable option for primary care physicians. Driving this trend nationally has been a combination of low reimbursement from public and private payers, along with the long and unpredictable work hours required in independent practice. In addition, specific to California, most physicians have long relied on the capitated HMO model — which pays better than PPO fee schedules — to sustain their practices financially. As commercial HMO products continue losing ground to high-deductible PPOs, financial strains on primary care practices have worsened to the point that many have been joining large system-affiliated groups, while some PCPs have retired without being able to sell their practice. New PCPs coming out of residency programs are overwhelmingly choosing the stability, security, and predictable work hours of the employment model over the autonomy of private practice.

This continuing decline of the small, independent primary care practice model poses major challenges for IPAs, whose core business is based on providing HMO contracting and practice support services to these practices. One San Diego provider even described the situation as an "existential threat to IPAs." If current trends continue, IPA physician membership and patient volumes are almost inevitably going to continue shrinking, and membership will skew more toward older physicians and specialists.

Some of California's largest IPAs are responding to these challenges by seeking to develop sustainable new models of primary care practice that can attract PCPs and prove financially viable for them. These new models are envisioned as smaller-scale, integrated group practices that aim to accommodate physicians seeking to practice part-time, keep practice overhead costs manageable and predictable, and provide physicians with clinical and administrative support without subjecting them to the bureaucracy of large groups.

Because IPAs lack the capital to pursue the development of these new models on their own, they have been forming or exploring partnerships with other organizations to gain access to capital.[17] In 2014, Hill Physicians, which has networks of independent physicians in several of Northern California's largest markets, began partnering with two of the state's largest health plans, Anthem Blue Cross and Blue Shield of California. Under the arrangement, the two plans provided Hill with capital by purchasing ownership stakes in PriMed, Hill's management services organization. Brown & Toland, a large IPA based in San Francisco and serving the Bay Area, reportedly has been exploring joint ventures and other affiliations with a range of partners but had not finalized any plans at the time of the site visits for these reports.

San Diego saw the emergence of a different type of collaboration — between one of the market's largest systems, Sharp Healthcare, and its tightly aligned IPA, Sharp Community Medical Group (SCMG) — to develop a new practice model for PCPs seeking employment. The new entity, SharpCare Medical Group, is to be rolled out in 2016 under Sharp's medical foundation. SharpCare is organized along very different lines than Sharp's large integrated group model, Sharp Rees-Stealy. The new medical group aims to retain some key attributes of small community-based practices that many independent physicians are reluctant to give up, while also offering physicians the stability and security of employment. Members would practice in relatively small offices with only about 3 to 10 primary care practitioners per site and would be able to continue referring patients to community-based specialists. At the same time, they would receive clinical support from the Sharp system — including from care management nurses, pharmacists, and other clinicians rotating among the primary care sites. Within the Sharp system, SharpCare would be most closely aligned with SCMG and would be a member of SCMG for HMO contracting and ACO participation. Fee-for-service PPO contracting for SharpCare will be done through Sharp Healthcare, which would have the leverage to obtain higher rates than small practices would receive on their own.

Discussion and Implications

Among the many types of provider collaborations that have proliferated in California over the past few years, by far the most ambitious — and potentially the most far-reaching in impact — are the initiatives aimed at creating region-wide integrated care networks. These efforts seek to transform the culture, incentives, and operations of provider organizations built largely to compete in a fee-for-service environment, and develop them into virtual Kaiser-like integrated systems emphasizing efficiency and value.

As noted above, the markets where most of these population health initiatives have been launched share some common characteristics: the presence of large, well-insured commercial populations; competitive pressure from a strong and expanding Kaiser; and large, deep-pocketed systems with strong infrastructure and sufficient capital to make major investments in building clinical integration, ambulatory capacity, and other essential elements of an integrated network. Markets with these traits tend to be the large population centers in more affluent communities, primarily along the coast. Although providers in other regions — such as the Inland Empire market in Riverside and San Bernardino Counties — also have begun to take tentative steps to establish integrated delivery systems, those efforts are more nascent, in part because key infrastructure such as medical foundations — essential for building strong physician networks — have only recently been launched.

Except for a handful of major systems that are pursuing population health management largely as a "go-it-alone" strategy, most large systems are partnering with other large systems to create integrated networks within their region. One key reason is that many systems, on their own, may not have a large enough clinical footprint to compete effectively for patients throughout an entire regional market, either in terms of geographic location of facilities or clinical expertise

and reputation. As a result, several systems have formed affiliations with other systems that can both add key geographic submarkets and bring complementary clinical strengths to the partnership. Compared to outright mergers and acquisitions, these collaborations allow systems to maintain greater autonomy, and subjects them to less regulatory scrutiny and lower costs and risks.

Many of the collaborations highlighted above whose scope and objectives are more limited — such as partnerships between hospital systems and providers of ambulatory or post-acute care — also play an important role in the larger population management strategies pursued by large systems. These partnerships can help fill key gaps along parts of the care continuum that hospitals had little incentive to focus on under a traditional fee-for-service environment — but that now become critical under arrangements rewarding coordinated and efficient care. At the same time, many of these collaborations also support hospital systems' ability to pursue other, more traditional strategies. For example, adding lower-cost freestanding ambulatory facilities to their networks helps systems better compete for the large population of price-conscious consumers whose insurance coverage subjects them to significant out-of-pocket costs. Several providers noted that the ability of certain collaborations to serve multiple, differing strategies in this way was particularly valued by their organizations as they seek to navigate a course between the two worlds of fee-for-service and value-based payment. Given the uncertainty about how much, and how fast, they will be able to transform their own care delivery systems to achieve population health management, investing in collaborations that can also serve other strategies allows large providers to "hedge their bets somewhat . . . [instead of] staking everything on [a strategy] that might not ultimately come to fruition . . . or might take a lot longer than anticipated to get there," a market observer noted.

As providers increasingly explore and engage in a range of partnerships and affiliations with other providers (and with health plans), the web of relationships among providers has become more complex. One market expert described providers in several large markets as taking a "more pluralistic approach to collaborations [and] avoiding getting locked into exclusive arrangements that might cause them . . . to miss out on the volume . . . and the opportunities . . . that other collaborations can bring."

An example is MemorialCare Health System, which is pursuing population health opportunities with different, though overlapping, sets of partners in Los Angeles and Orange Counties. As a member of Vivity, MemorialCare is sharing full risk for large groups with seven other systems and Anthem Blue Cross; at the same time, its MemorialCare Health Alliance (which includes two other Vivity members as well as UC Irvine, which is not part of Vivity) is pursuing risk contracts with other large groups and recently signed a contract with large employer Boeing. Meanwhile, in the Bay Area, John Muir Health is engaging in simultaneous, separate strategic partnerships with UCSF and Stanford for adult medicine and pediatrics, respectively — another example of how the web of provider linkages has grown, and become more complex, over the past few years.

If the new region-wide integrated networks being launched by large providers succeed in gaining widespread traction, they could help revive commercial capitation — which has long been in slow decline relative to high-deductible PPOs and Kaiser HMOs across major markets in the state. The new networks also are expected to intensify price competition and expand the range of choices of insurance products and provider networks available to purchasers and consumers. Some markets have felt these beneficial impacts already, as the launch or expansion of provider-sponsored health plans has led to strong competition with Kaiser, resulting in reduced premiums (or at least a moderation of premium trends) for some purchasers.

However, increased provider competition and its resulting benefits to purchasers and consumers will prove sustainable only if providers can continue lowering their cost structures and moving toward truly integrated and efficient care

delivery. Currently, some providers appear to be undercutting Kaiser premiums and gaining market share only by subsidizing their new HMO products substantially — clearly not a viable approach beyond the short term. Most systems are still in the very early stages of the long and difficult journey toward clinical integration, a journey complicated by conflicting incentives both within their own organizations and across partnering providers.

Several observers also expressed concern that growing provider consolidation — even in the form of affiliations and joint ventures rather than outright mergers — would increase the market clout held by large providers, which would ultimately raise the potential for reduced competition and higher prices in health care markets.

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Ha Tu of **Mathematica Policy Research**. Mathematica is dedicated to improving public well-being by conducting high-quality, objective data collection and research. More information is available at **www.mathematica-mpr.com**.

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Background on Regional Markets Study

In 2015, a team of researchers from Mathematica Policy Research visited seven California regions to understand these markets' local health care systems and capture change since 2011/2012, the prior round of this Regional Market Study, funded by the California Health Care Foundation. The purpose of the study is to gain insights into the organization, delivery, and financing of health care in California and to understand differences across regions and over time. The seven markets included in the project — Fresno (including Fresno, Tulare, Kings, Madera, and Mariposa Counties), Los Angeles County, Orange County*, Riverside and San Bernardino Counties, Sacramento (including Sacramento, Yolo, El Dorado, and Placer Counties), San Diego County, and the San Francisco Bay Area (including San Francisco, Alameda, Contra Costa, Marin, and San Mateo Counties) — together are home to three-quarters of California residents and reflect a range of economic, demographic, health care delivery, and financing conditions in California. Mathematica researchers interviewed over 200 respondents for this study. Respondents included executives from hospitals, physician organizations, community health centers and other community clinics, Medi-Cal health plans, and other local health care leaders. For this cross-site analysis, researchers conducted follow-up interviews with select respondents (primarily market observers and executives from hospital systems and physician organizations) and tracked local media sources to capture updates since the site-visit interviews.

▶ FOR THE ENTIRE REGIONAL MARKETS SERIES, VISIT WWW.CHCF.ORG/ALMANAC/REGIONAL-MARKETS.

*Orange County was added to this study in 2015; the research team had familiarity with this market through the prior Community Tracking Study conducted by the Center for Studying Health System Change (HSC), which merged with Mathematica in January 2014.

ENDNOTES

1. Jonathan Spees, "Choosing the Right Affiliation Structure," *Hospitals & Health Networks Daily*, October 9, 2014, **www.hhnmag.com**.

2. Some competing providers and market observers view the St. Joseph-Hoag transaction as a full merger (with Hoag effectively joining the St. Joseph system) rather than an affiliation or joint venture.

3. Chad Terhune, "Boeing Contracts Directly with California Health System for Employee Benefits," *Kaiser Health News*, June 21, 2016, **khn.org**.

4. "Boeing and MemorialCare Health System Partner on Boeing's First California Customized Health Plan Option Offering Better Benefits and Lower Costs for Boeing Employees and Their Families," *PR Newswire*, June 21, 2016, **www.prnewswire.com**.

5. Kristen Bole, "Bay Area Accountable Care Network Takes Shape," *UCSF News Center*, July 28, 2016, **www.ucsf.edu**.

6. The seven hospitals added to Canopy Health's network are Alameda Health System's Alameda, Highland and San Leandro hospitals, Marin General Hospital, San Ramon Regional Medical Center, Sonoma Valley Hospital, and Washington Hospital Healthcare System.

7. Chris Rauber, "Exclusive: UCSF, John Muir Dramatically Expand, Rename Bay Area Health Network," *San Francisco Business Times*, July 27, 2016, **www.bizjournals.com**.

8. Vivity's other participating providers are Good Samaritan Hospital, Huntington Memorial Hospital, MemorialCare Health System, PIH Health, and Torrance Memorial Medical Center.

9. Brett Brune, "How Anthem's Vivity Venture Is Faring in Southern Calif. Showdown with Kaiser," *Modern Healthcare*, October 23, 2015, **www.modernhealthcare.com**.

10. Unlike other systems described in this section, which are developing population health strategies for the first time, Sharp has long pursued these strategies. Since 2014, Sharp has expanded the patient populations for whom it competes directly through its own health plan; these now include CalPERS members and Covered California (public insurance marketplace) enrollees.

11. For a list of the Trio ACO HMO network's presence by county and by commercial segment, see **www.blueshieldca.com**.

12. Paul Sisson, "Scripps Health Expands with Clinics, Insurance Plans," *San Diego Union-Tribune*, December 1, 2015, **www.sandiegouniontribune.com**.

13. Bernie Monegain, "CVS Partners with John Muir, Novant Health, Michigan Health and University of Chicago for Clinics," *Healthcare IT News*, January 15, 2016, **www.healthcareitnews.com**.

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15. Paula S. Katz, "Walking the Walk in Transitional Care," *Today's Hospitalist*, February 2012, **www.todayshospitalist.com**.

16. *Medicare's Post-Acute Care: Trends and Ways to Rationalize Payments*, online appendixes in *Report to the Congress: Medicare Payment Policy*, Medicare Payment Advisory Commission, March 2015, **medpac.gov** (PDF).

17. Because IPAs must distribute all surplus earnings to their members at the end of each year, they tend to lack sufficient capital internally to fund such initiatives.