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Physician-Hospital Integration 2012

How Health Care Reform Is Reshaping California's Delivery System

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By

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I. Executive Summary

For several decades, most physicians and hospitals have worked with each other independently, in arm's length, fee-for-service arrangements. Over time, however, these arrangements have come to be viewed as contributing to rising health care costs and significantly driving uncoordinated care, duplication of services, and inadequate patient access. In addition, physicians and hospitals alike have faced increasingly challenging economic conditions, particularly since the recession of the late 2000s. The economic outlook for providers has further been challenged by provisions of the Patient Protection and Affordable Care Act (ACA) and by continued cuts in Medicare and Medicaid reimbursement that have taken the form of reductions both in the volume of Medicare patients that providers see and in reimbursement rates. Finally, issues related to physician income and work/life balance have caused a shift in the types of specialties physicians choose, as well as in the availability of physicians to practice medicine in California, driving hospitals and other provider organizations to develop mechanisms to aggregate physicians in their medical staff models.

In response, physician organizations' interest in integrating or partnering with other entities has markedly increased, in particular to limit their exposure to financial risks. This paper explores the impact of the economic environment and of recent health care reform initiatives on physician-hospital integration activity in California. It builds on a 2010 California HealthCare Foundation paper, *Physician-Hospital Integration in the Era of Health Reform*, and presents not only research findings but also perspectives gleaned through interviews with leaders at hospitals, physician groups, health plans, and provider industry associations, which shed light on how these organizations are approaching integration. In addition, the paper offers case studies on six provider organizations across the state — Adventist Health, Arrowhead Regional Medical Center, John Muir Health, Presbyterian Intercommunity Hospital, Scripps Health, and the University of California, San Francisco Medical Center — about their current and future integration plans in light of recent trends.

Impact of the Affordable Care Act

The passage of the ACA has propelled issues regarding physician-hospital integration onto the national stage. During 2011, many specifics emerged regarding how health care reform will be implemented, spurring physicians and hospitals to change and accelerate their alignment structures with one another. Across the state, providers of all stripes have been evaluating how the ACA's mandates — quality excellence, population health management, efficiency, and cost savings — can be realized in light of economic, political, and market constraints. In many cases, organizations are implementing pilot projects to assess the impact and sustainability of alignment models prior to broad adoption. The future landscape of care providers and models of care delivery in California will be shaped by these efforts.

Federal Spurs to New Integration Mechanisms

In early 2011, the Centers for Medicare & Medicaid Services began to define the future mechanisms by which Medicare and Medicaid providers will be evaluated, structured, and compensated. The Center for Medicare & Medicaid Innovation (CMMI), created by the ACA, launched a series of voluntary initiatives that implement the vision of the Institute for Healthcare Improvement's Triple Aim™: better population health, better patient experience, and reduced health care costs. Future integration efforts in California and across the nation are likely to be defined, in part, by the following federal payment initiatives:

- *Health Care Innovation Challenge.* Awards up to $1 billion in grants to fund innovative service delivery and payment models to support sustainable patient care improvement projects.
- *Comprehensive Primary Care Initiative.* Works with commercial and state health insurance plans to offer bonus payments to primary care doctors for initiatives that improve patient care coordination.
- *Federally Qualified Health Centers (FQHC) Advanced Primary Care Practice Demonstration.* Tests the effectiveness of doctors and other health professionals working in teams to improve care coordination for Medicare patients at FQHCs.
- *Bundled Payments for Care Improvement.* Allows providers to use bundled payments as a way to increase efficiency and value in clinical care delivery. In particular, provider organizations may apply to receive Medicare Part A and Part B payments for specified clinical services in a single "bundled" payment.
- *Accountable Care Organization (ACO).* Within an ACO, primary care physicians use care management processes to efficiently meet the health care needs of Medicare beneficiaries. Most ACOs are separate legal entities composed of provider organizations such as independent physician practice networks, medical group practices, and integrated delivery systems.

According to the California Department of Health Care Services, the insured patient population in the state is expected to increase by nearly 4 million by 2016; it is anticipated that the above-described initiatives will help alleviate capacity constraints across many sites of care.

Integration Brings Together Unexpected Partners

Regulatory, quality, and financial demands have driven physicians — in particular, solo practitioners and specialty groups — to seek alignment opportunities in ever increasing numbers. Some small- to medium-size physician groups have sought to merge or close their practices, often seeking to participate in a larger physician group, health system-based medical foundation, or other integrated structure such as an outpatient clinic. The majority of health care organization leaders interviewed for this paper believe that this integration trend by physician practices is likely to continue for the foreseeable future.

California's prohibition on the direct employment of physicians by entities other than professional corporations has historically limited hospitals from closely integrating with physicians. Over the last several years, however, hospitals and health systems have increasingly turned to medical foundations and other mechanisms for formal alignment. For example, among the six hospitals and health systems featured in this paper's case studies, only one does not have a medical foundation or exclusively contracted medical group. However, new models of care have not been uniformly embraced among California providers. Elements of integration — including care management models, participating organizations, performance standards, and financial incentives — vary widely between geographic regions and segments of providers.

Payers, too, have increasingly aligned with providers in management and administrative arrangements. In some instances, this has taken the form of ACOs or other shared-risk models between payers and provider organizations. In other cases, payers have actually acquired physician organizations or invested in their management companies. Among insurers with significant enrollment in California, UnitedHealth Group and Wellpoint (Anthem Blue Cross of California) have announced acquisition strategies to form stronger relationships with physician practices.

Implications for Policymakers

While many benefits may be realized from physician-hospital integration, there are a number of matters that California policymakers will need to consider with respect to current trends.

- **Impact of Provider Consolidation on Pricing for Patient Services.** Consolidation of provider organizations could increase the price of patient services. As hospitals, medical groups, and other provider organizations form collaborative networks such as ACOs, or merge with one another, patients will have fewer choices from which to receive clinical care. Market consolidation may give remaining competitors leverage to increase prices. In California, the net impact of increasing provider consolidation on pricing remains to be seen. Ultimately, the impact of provider consolidation may be mitigated somewhat by payers, who are stepping up pressure to reduce prices and increase transparency of cost and quality reporting. In addition, the rollout of benefit models that encourage use of lower-cost providers may further dampen the market effects of integration.
- **Appropriate Patient Access to Clinical Services.** Alignment of provider and payer incentives and the pressure to reduce costs may have the unintended consequence of reducing access to needed medical services. Regulations requiring disclosure of health plan performance regarding access to care will continue to be of great importance. Further, the actions of payers and providers in the coverage and management of clinical services will need to be monitored and evaluated.
- **Effect of State Budget Cuts.** Ongoing state budget cuts may limit the ability of providers to realize the goals of their integration efforts. Pediatric and safety-net providers, in particular, have withstood recent reimbursement cuts but are vulnerable to future reductions, particularly in light of increased demand due to rising Medi-Cal and Healthy Families enrollment, which is likely to be exacerbated in 2014 as eligibility expands for Medi-Cal and other subsidized insurance. Many of these providers also lack the infrastructure and mechanisms necessary to successfully enable physician-hospital integration. On the positive side, government grants, such as those offered by CMMI through the Innovation Challenge, may provide avenues to jump start programs that will improve access to care for vulnerable patient populations.
- **Strain on Safety-Net Providers from Increased Patient Demand.** The expansion of insurance coverage to previously uninsured populations, plus the implementation of the California Health Benefit Exchange, will likely increase operational stress on safety-net providers such as FQHCs, rural health clinics (RHC), and public hospitals. To date, these providers have not been able to meet patient demand, due to limitations in physician coverage and facility space. The 2011 introduction of state funding to address infrastructure constraints and development opportunities is expected to help address these issues, but other steps may be needed to ensure timely access to care.
- **Uncertainty for Safety-Net Providers Regarding Newly-insured Medi-Cal and Commercial Patient Populations.** While some providers that serve safety-net populations are concerned about staffing shortages, others fear that patients covered by richer health insurance benefits will be referred to "mainstream" health care providers because of improved reimbursement. If so, the financial impact on providers who serve uninsured and underinsured populations would be significant. While the magnitude of this issue is not yet known, providers that serve the safety net should take steps to improve their care delivery and relationships with physicians through enhanced clinical, financial, and technological integration strategies. Initiatives underway as part of the Bridge to Reform program are designed to facilitate these improvements, but their adequacy is yet to be determined.

II. Introduction

Over the past decade, economic pressures on physicians and hospitals have generated increased attention by both on the need to create structures and systems that enhance integration and collaboration between providers. The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 further propelled issues regarding physician-hospital integration onto the national stage. Though the policy and regulatory specifics of the ACA are still being developed, providers who are mindful of the law's implications for improved care coordination, quality, and efficiency are evaluating new models of alignment.

This paper builds on a 2010 California HealthCare Foundation report, *Physician-Hospital Integration in the Era of Health Reform*, and explores the impact of the current economic environment and of recent ACA-related initiatives on physician-hospital integration activity in California. In addition to research findings, this paper presents perspectives from leaders at hospitals, physician groups, health plans, and provider industry associations about how these organizations are approaching integration.[1] The paper concludes with case studies on six provider organizations across the state about their current and future integration plans in light of recent trends.

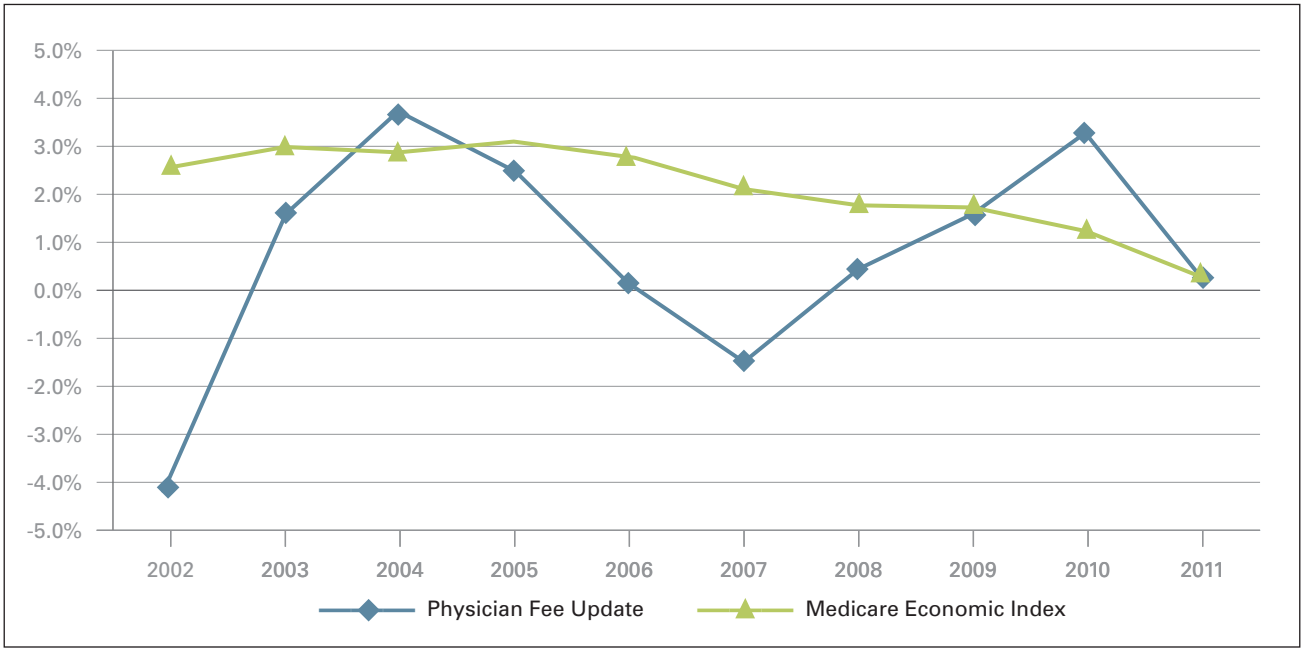
III. The Physician-Hospital Economic Environment

Eroding Provider Revenue

A changing economic landscape for physicians and hospitals, exacerbated by the most recent economic downturn, has accelerated their interest in provider integration, according to research and interviews conducted for this report. The economic downturn changed the mix of insurance enrollment in many regions in California. During the last several years, both physicians and hospitals have seen greater proportions of uninsured and Medi-Cal patients: Medi-Cal enrollment increased nearly 13% between 2007 and 2010, while enrollment in commercial insurance plans fell.[2] This shift has negatively affected the financial picture for providers, since many depend on revenue from commercial insurance to offset losses from government payers. Moreover, according to data from the Office of Statewide Health Planning and Development (OSHPD), overall hospital discharges in California were relatively flat between 2008 and 2010, increasing by only 0.4%, meaning that volume growth has failed to offset lower revenue per discharge.

With regard to physicians' reimbursement for the large Medicare patient population, in most years between 2002 and 2011 Medicare's annual update to the physician fee schedule has trended at or below the Medicare Economic Index (MEI), a measure of physician practice operating costs. Over the entire period, annual updates in the physician fee schedule averaged 0.8%, compared to an average for the MEI of 2.2%.[3] (See Figure 1.)

Figure 1. Medicare Physician Fee Schedule Annual Updates, 2002-2011



Note: Physician fee schedule update figures include all legislation impacting payment updates but exclude updates related to risk adjustment.

Sources: 2011 Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, and The Camden Group.

Medicaid fees, especially for California's Medi-Cal program, have also fared badly. In late 2011, the Centers for Medicare & Medicaid Services (CMS) approved a 10% reduction to the Medi-Cal physician fee schedule. California currently has the fourth lowest Medicaid rates in the nation, paying 56% of Medicare rates on average.[4]

Medicare margins for hospitals are also on the decline. According to a 2011 report issued by the Medicare Payment Advisory Commission, margins on Medicare patients for nearly all major hospital groups, including critical access hospitals and major teaching hospitals, remained negative in 2010.[5] About 64% of hospitals reported financial losses on Medicare patients.[6] (For-profit hospitals broke even in 2010.)

Additional risks to physician reimbursement loom. Congress has yet to find a permanent solution to Medicare's sustainable growth rate (SGR) formula, a cost control method introduced in 1997 that limits Medicare beneficiary expense growth to a level not exceeding annual Gross Domestic Product growth. In every year since 2003, Congress has temporarily postponed these reductions to the following year. In November 2011, CMS announced 27% in cuts to Medicare physician payments effective January 1, 2012.[7] The following month, Congress passed a measure that delayed the onset of the cuts until March 1, 2012, to buy legislators time to find a long term solution to the SGR. In February 2012, Congress passed legislation freezing current rates until 2013.[8] That same month, President Obama also introduced a federal budget proposal that includes a provision giving physicians a two-year reprieve from SGR payment cuts.[9]

Insurers Continue to Do Well

While reimbursement to physicians and hospitals has continued to fall, the nation's largest payers have maintained considerable financial success despite declining membership enrollment across the health insurance industry. This implies that payers have become more effective at utilization management and at provider contracting tactics, thus improving their profitability.[13]

Commercial insurers have been under greater pressure by state regulators to mitigate excessive rate increases, particularly for individual and small group insurance products. Further, the ACA mandates a minimum medical loss ratio (the amount of health care premiums spent on medical costs) of 80% for the individual and small group market and 85% for large employers. One of the ways that insurers have maintained their profitability during difficult economic times and this government oversight has been to take an increasingly tough stance in provider contract negotiations. In a 2011 national survey of hospital leaders responsible for payer contracting, 64% of respondents reported having annual average reimbursement increases of 7% or less.[14] Despite state regulation, insurers have also increased employer and beneficiary premiums to increase their profitability.

Other cuts are expected in 2013, the result of federal deficit reduction efforts. In November 2011, the congressional Joint Select Committee on Deficit Reduction, tasked with developing a plan that might include a solution to the SGR formula, failed to come up with a proposal.[10,11] The failure of this deficit reduction "super committee" to recommend a plan means Medicare Part A and Part B payment cuts of 2% each year from 2013 through 2021 will go into effect automatically, though Congress could still prevent some or all of the cuts by passing other deficit reduction measures before 2013.[12]

Physician Workforce Issues

Across the nation, the physician workforce has weathered challenges that are fundamentally changing the way medical groups and hospitals relate to each other. Issues related to physician income and work/life balance have caused a shift in the types of specialties chosen, as well as in the availability of physicians to practice medicine in the state. In a 2007 survey, more than 40% of primary care physicians in California reported dissatisfaction with both medical practice income and time spent per patient.[15] According to analysis by Dartmouth College researchers, today's physicians work four fewer hours per week than physicians practicing in 1976, a reduction equivalent to having 36,000 fewer doctors in the national workforce.[16]

Statistics on the number of active physicians in California indicate that, while the current count minimally meets the state's population needs, patient access issues persist due to uneven geographic distribution of physicians across the state. According to the California Medical Association, 74% of California counties report primary care physician shortages, and 45% of counties report specialist shortages.[17] As of 2010, California ranked 20th nationally in the number of active physicians by population, and 26th in terms of active primary care physicians.[18] Finally, Medi-Cal patients in many communities have reported difficulty in obtaining appointments with specialists.[19] Medi-Cal beneficiaries are more likely to be turned down by physicians and are four times more likely to receive treatment in a hospital emergency department because they could not get doctor or clinic appointments.[20] California's lower-than-average reimbursement rates are a contributing factor to the state's primary care physician shortage. Revenue for primary care physicians in California is 12% less than for comparable physicians in other states.[21]

A study by the Association of American Medical College's Center for Workforce Studies found that the effects of health care reform will likely compound national physician shortages. Projected need for additional physicians across the United States will increase from 39,600 to 62,900 by 2015. Of those physicians needed, 33,100 are non-primary care specialists.[22]

These changing workforce dynamics have compelled leaders of provider organizations to develop new models for physician alignment and leadership, in part to improve medical staff recruitment and retention. Many hospitals, facing physician recruitment challenges and shortages, have embraced integration as a means of improving patient access to care and solidifying their competitive positions. Likewise, increasing numbers of physicians have sought refuge in larger medical groups and hospital-sponsored medical foundations in order to mitigate financial pressures and provide a more secure platform for responding to new payment models and competitive strictures. In addition to increasing alignment between physicians and hospitals, provider shortages are fostering the development of new care delivery models that are less reliant on face-to-face encounters and build on technology-based solutions such as e-visits, as well as more fully utilizing the skills of the entire care team to reduce time pressure on physicians. Larger physician groups and medical foundations are better able to craft such solutions because of their medical leadership oversight, more highly developed process improvement skills, and access to more sophisticated technology.

IV. Emerging Integration Initiatives in the Wake of the ACA

In early 2011, CMS began to define the future mechanisms by which Medicare and Medicaid providers would be evaluated, structured, and compensated. The Centers for Medicare and Medicaid Innovation (CMMI), created by the ACA, launched a series of voluntary initiatives to implement the vision of the Institute for Healthcare Improvement's Triple Aim™: better population health, better patient experience, and reduced costs. Future integration efforts will be defined in light of these national initiatives. The following sections describe how each of these models influences physician-hospital integration.

Ongoing Pre-ACA Integration Efforts

Well before passage of the ACA, economic and other factors were impelling many physicians to explore alternative relationships with hospitals and other provider organizations. Among these integration strategies, physicians have increasingly sought to align with provider organizations that offer employment-like arrangements, such as medical foundations. Other arrangements, such as co-management for specific hospital services and provider organization mergers, have also been developed. For a detailed discussion of pre-ACA integration models and the factors that have driven them, see The Camden Group's *Physician-Hospital Integration in the Era of Health Reform*, published by the California HealthCare Foundation in 2010.[23] Also, to help curtail financial losses, physicians and hospitals alike have increased activity seeking to eliminate inefficient medical practices. Examples of such areas of inefficiency include variation in physician practices, lack of standard protocols, and lack of communication between providers.

Emergence of Medicare Accountable Care Models

Within a Medicare Accountable Care Organization (ACO), primary care physicians use care management processes to efficiently meet the health care needs of Medicare beneficiaries. Leaders of provider organizations initially embraced the concept of ACOs as an opportunity to facilitate Medicare population health management. However, response was mixed, at best, to proposed regulations by CMS on the requirements for Medicare ACOs, to begin in 2012. Among organizations' primary concerns were patient "attribution," organizational complexity, extensive quality measures, limited opportunity for sharing savings, requirements to take risks for losses, and compliance standards. Many organization leaders estimated that the capital investment requirements to meet information technology and compliance guidelines could outpace potential ACO savings for many providers. (For a general description of the two Medicare ACO programs, see "Overview: CMS Accountable Care Programs," on page 10.)

In particular, the initial Shared Savings Program (SSP) ACO models included elements that limited cash flow and increased financial obligations to well beyond the risk thresholds for many organizations. Overall, concern about the financial risk required of ACOs, coupled with both limited shared savings potential and organizational complexity, created skepticism among many about whether the CMS ACO initiative would be pursued by more than just a handful of organizations.

On the other hand, some California systems and medical groups experienced in managing patients under Medicare Advantage and commercial capitation arrangements were encouraged by the Pioneer ACO Program, introduced by CMMI in August 2011. Many providers with capitation experience, specifically

with Medicare Advantage plans, have infrastructure in place to connect and coordinate providers. The Pioneer model can reward these organizations with a large financial "upside." The model can also provide a means for these organizations to transition fee-for-service Medicare patients to partial population-based payment arrangements in the third year of program participation. Six providers in California were initially approved as Pioneer ACOs, making it the state with the most providers participating in the program; Massachusetts ranks second with five providers approved for the program. (For a list of approved California Pioneer ACO providers, see Table 5, on page 20 of this paper.) Outside of California, however, some organizations touted as national leaders in integrated care delivery — including Mayo Clinic, The Cleveland Clinic, Geisinger Health System, and Intermountain Healthcare — declined to participate in the Pioneer ACO program.[24]

The final SSP regulations, released in October 2011, addressed industry concerns by significantly reducing the number of quality measures ACOs are required to report, and by reducing electronic health record eligibility and other eligibility and compliance requirements. Patient attribution was also modified to improve confidence in identifying individuals for whom the organization would be responsible. The prospect of financial risk for providers was also addressed, by eliminating the "downside" risk for those organizations

Overview: CMS Accountable Care Programs

As defined by the ACA, Medicare ACOs are legal entities composed of provider organizations that use primary care physicians and care management processes to efficiently meet the health care needs of Medicare beneficiaries. Eligible organizations may include independent physician practice networks, medical group practices, acute care hospitals that employ ACO-eligible physicians, joint venture arrangements between hospitals and professionals, critical access hospitals, rural health clinics, and FQHCs. (For details about Medicare ACOs and comparison with other federal government initiatives, see Table 1 on page 12.) Beginning in 2012, providers may qualify to participate in two Medicare ACO programs:

- *Pioneer ACO*. This model is intended for provider organizations that have robust processes of care and the infrastructure and experience necessary to eventually assume responsibility for enrolled Medicare beneficiaries in a population-based payment model. Participating ACOs must meet the same quality reporting and other organizational requirements as do SSP ACOs. Compared to the SSP, the Pioneer ACO program has higher shared savings and loss rates. It also allows providers the option of changing the reimbursement model from fee-for-service to partially capitated payments in the third year of the program. This program is managed by CMMI, which has selected 32 organizations across the nation, based on those organizations' perceived readiness to take on additional risk and large populations (at least 15,000 Medicare fee-for-service beneficiaries).
- *Shared Savings Program*. The SSP is intended for provider organizations that have less care coordination and patient management experience but that nonetheless have the ability to coordinate care and meet quality reporting requirements. The SSP has two shared savings tracks for ACOs to choose from: Track One offers only shared savings, while Track Two offers sharing in both savings and losses.

To foster program participation among critical access, rural, and physician-owned organizations, CMMI has instituted the Advance Payment Model initiative. Upfront and ongoing payments to support development and care coordination initiatives will be awarded under this initiative, to test whether such payments will encourage SSP participation among safety-net providers.[27] A participating ACO may qualify for payments based on either one of the following eligibility requirements:

- It does not include any inpatient facilities, and has less than $50 million in total annual revenue.
- It includes critical access hospitals and/or Medicare low-volume rural hospitals, and has less than $80 million in total annual revenue.

that prefer a lower risk option. These changes effectively opened the door for organizations with less experience in population-based health management to begin the process of care delivery transformation through the SSP.

Health care industry associations — including the American Medical Association, the National Association of Public Hospitals and Health Systems, and the American Hospital Association — applauded the changes CMS made in the final SSP rules.[25] Leaders of provider organizations, however, continued to be cautious about the feasibility of program participation. According to a HealthLeaders Media article, many provider leaders expressed "serious concern" with the final SSP regulations. Leaders cited the cost and difficulty of establishing the ACO infrastructure, the complexity of the system, and the three-year time commitment as the primary roadblocks. Many also questioned whether the savings, if realized, would justify investment in an ACO.[26]

Other CMS Integration and Payment Reform Initiatives

ACOs are only one of numerous tools the federal government has recently developed to facilitate payment reform and to achieve the Triple Aim™ with regard to Medicare populations. CMS has developed other pilot projects with three aims: to improve the availability of primary care, to facilitate new care models (e.g., the Health Care Innovation Challenge, the Comprehensive Primary Care Initiative, and the Federally Qualified Health Center Advanced Primary Care Practice Demonstration), and to directly reduce the costs associated with acute care and post-acute care services (e.g., the Bundled Payments for Care Improvement Initiative). For a side-by-side comparison of these initiatives, see Table 3 on pages 14 -15.

These voluntary initiatives have brought together providers to focus on care delivery processes and effective medical management for Medicare beneficiaries. These initiatives do not require physicians, hospitals, or other providers to be joined through a single legal entity. As CMS moves away from traditional fee-for-service payment models, which pay individual providers for discrete services, into those that provide a shared incentive to meet the Triple Aim™, physicians, hospitals, and other providers are rewarded for collaborating and exploring new innovative models of care.

Health Care Innovation Challenge

Designed to test creative ways of improving health care quality and lowering costs, the Health Care Innovation Challenge will award funds to projects that leverage new service delivery and payment models. Up to $1 billion in total grants is to be awarded, with preference given to projects focused on high-risk patient populations. The initiative is open to a broad array of applicants, including health systems, payers, community collaboratives, for-profit organizations, local governments, public-private partnerships, and private sector organizations. Applications were due in January 2012, with awards to be announced in March and August of 2012.

Comprehensive Primary Care Initiative

Scheduled to launch in 2012, this initiative is focused on providing incentives to primary care physicians for improved coordination of patient care. Public and private payers can apply for funds to support wellness programs, proactive patient health management, and referring physician communications. Physicians and payers have the opportunity to share in savings generated for the duration of the program.

FQHC Advanced Primary Care Practice Demonstration (also known as the FQHC Medical Home Demonstration)

To support the transformation of FQHCs into providers of team-oriented, coordinated, patient-centered care, participating practices can receive a monthly care management fee of $6 per eligible Medicare beneficiary in addition to the established all-inclusive visit payment. Nationally, more than 500 FQHCs are participating in the three-year demonstration project, which began November 1, 2011; in California, 70 FQHCs are participating in the program. (For participating sites in California, see Appendix A.)

Bundled Payments for Care Improvement Initiative

This initiative is focused on encouraging acute and post-acute care hospitals and other providers to effectively manage the utilization of services and care delivery costs through collaboration with physicians and other providers. Beginning in 2012, participating hospitals receive a single "bundled" payment for services provided for an entire episode of care (as defined by each bundle). Hospitals propose Medicare Severity-Diagnosis Related Groups (MS-DRG) to be included in the episode. An episode may include readmissions and post-acute care services provided after discharge. Depending on the types of clinical episodes selected, hospitals may participate in one of four models. (See Table 1.) Applications for Model 1 were due in November 2011; applications for the other models are due in late April 2012, with bundled arrangements expected to begin in October 2012.

Expanding Participation in Health Insurance

As a result of the ACA, the number of people insured in California will significantly increase. California's Bridge to Reform program has reallocated state funds to pay for enrollment expansion in Medi-Cal and state insurance programs through 2016. Further, enrollment in Medi-Cal and Healthy Families is expected to increase by 1.7 million beginning in 2014, to nearly 8.5 million.[28] Federal subsidies for individuals and families with incomes within 400% of the Federal Poverty Level (FPL) will increase commercially insured enrollment by nearly 2 million by 2016. (See Table 2 on page 13.)

To ensure that all eligible citizens are able to access affordable health care insurance, the ACA authorized the creation of state-based health insurance exchanges. Scheduled to be operational by the annual enrollment

Table 1. Bundled Payment Models

	MODEL 1: INPATIENT STAY ONLY	MODEL 2: INPATIENT STAY PLUS POST-DISCHARGE SERVICES	MODEL 3: POST-DISCHARGE SERVICES	MODEL 4: INPATIENT STAY ONLY
Pricing Method	Discounted payments, no separate target price	Retrospective comparison of target price and actual fee-for-service payments	Retrospective comparison of target price and actual fee-for-service payments	Prospectively set payments
Clinical Conditions	All MS-DRGs	Applicant to propose based on MS-DRG for inpatient hospital stay	Applicant to propose based on MS-DRG for inpatient hospital stay	Applicant to propose based on MS-DRG for inpatient hospital stay
Expected Discount Provided to Medicare	To be proposed by applicant CMS requires minimum discounts, increasing from 0% in first six months to 2% in Year 3	To be proposed by applicant CMS requires a minimum discount of 3% for episodes of 30 to 89 days post-discharge, and 2% for episodes of 90 days and longer	To be proposed by applicant	To be proposed by applicant Subject to a minimum discount of 3% Larger discounts for MS-DRGs in Acute Care Episode Demonstration

Sources: Centers for Medicare & Medicaid Services and The Camden Group.

Table 2: Projected Impact of ACA on Commercially Insured Populations (2016)

	PRE-ACA (MILLIONS)	POST-ACA (MILLIONS)	CHANGE (MILLIONS)
U.S.	190	206	16
California	21	23	2

Source: J. Gruber and P. Long, "Projecting the Impact of The Affordable Care Act on California," *Health Affairs* 30, no.1 (2011): 65.

period for calendar year 2014, it is anticipated that these insurance exchanges will facilitate insurance coverage for millions of patients, including low- and middle-income families. To support the process, the federal government has awarded more than $235 million in grants to fund the development of exchanges at the state level.

Individual states have latitude whether to develop an insurance exchange and, if they do, on how best to implement it. States that fail to implement their own exchanges will be required to give residents access to the federal health insurance exchange. Across the nation, 17 states have so far established plans to build a health insurance exchange.[29] In some cases, governors have issued executive orders to adopt health insurance exchanges, bypassing state legislative politics to advance exchange development. Another 11 states have either failed to pass laws establishing an exchange or do not plan to launch a state-based insurance exchange.

California has embraced the health benefit exchange concept. The state was the first in the nation to approve legislation to establish a state health insurance exchange. Information technology enhancements to improve ease of access to health benefit information, particularly for low-income enrollees, plan options and costs, and expedited eligibility and enrollment processes, have all become priorities for the state. By November 2011, California had received nearly $40 million in federal planning and establishment grants for its Health Benefit Exchange.[30]

California's exchange is expected to offer plan options within five coverage levels, from "platinum" plans with high premiums that cover 90% of medical expenses, to "bronze" plans with low premiums that cover 60% of medical expenses. Aside from the variation in medical services covered by each coverage level, there may be distinct variation in provider networks offered. Federal subsidies will help individuals and families between 133% and 400% of the FPL; the majority of these enrollees may choose to purchase insurance plans in lower coverage levels to save money.[31, 32] Payers offering plans via the Health Benefit Exchange will be able to define the provider networks for each coverage level as a means of controlling costs. Plans in lower coverage levels, such as "bronze" plans, will also likely restrict covered benefits; access to certain providers may allow only for out-of-pocket fees, or present other restrictions. Network strategies such as this would alter physician and hospital referral patterns and patient volumes.

In light of these changes, hospitals and physicians share an interest in jointly pursuing payer strategies to preserve existing referral and patient relationships. Concerns about being excluded from a network developed by a payer for participation in a state health benefit exchange are compelling many physicians and hospitals to develop inclusion strategies. This means looking at cost reduction strategies, evaluating primary care access points, and pursuing ACO-like initiatives with payers to share in cost savings and patient outcome achievements. Further, initiatives to redesign care processes and staffing to improve capacity, in preparation for increased numbers of insured patients, require collaboration between hospital and physician providers. These factors, in combination with other components of payment reform, serve to reinforce the need for all types of providers (including hospitals, physicians, and post-acute providers) to form new or reinforced alliances in order to remain relevant in the evolving health care market.

Table 3. CMS Integration and Payment Reform Programs

HEALTH CARE INNOVATION CHALLENGE	COMPREHENSIVE PRIMARY CARE INITIATIVE	FQHC ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION	BUNDLED PAYMENTS FOR CARE IMPROVEMENT	ACO (PIONEER AND SSP)
Description				
Awards up to $1 billion in grants to fund innovative service delivery and payment models to support sustainable patient care improvement projects	Works with commercial and state health insurance plans to offer bonus payments to primary care doctors to support initiatives that improve patient care coordination	Tests the effectiveness of doctors and other health professionals working in teams to improve care coordination for Medicare patients at FQHCs	Develops models of bundling payments through four broadly defined models of care, three of which involve a retrospective bundled payment arrangement with a target payment amount for a defined episode of care	Presents opportunity for gain-sharing from savings that result from improvements in care delivery for Medicare fee-for-service patients through the effective deployment of primary care services
Model Attributes				
Awards expected to be $1 million to $30 million each Care improvement to be demonstrated within six months of award Should enable rapid deployment of health care workforce Emphasis on high-risk patients	Encourages collaboration between primary care physicians and payers to test two models to improve care quality and costs Emphasis on development of care coordination processes Specific initiatives at the discretion of the payer	Delivery of timely, coordinated medical care Multi-disciplinary team led by primary care physicians Emphasis on high-risk patients	Flexible, may include acute hospital and follow-up care, and all inpatient services or select clinical episodes Hospital or convener determines services included in the care bundle Does not require creation of a separate legal entity to participate	Providers assume responsibility for cost and quality for defined population Requires entity that has Tax Identification Number to accept shared savings (or losses)
Payment Implications				
Limited; projects may include payment redesign or other reimbursement-related initiatives	Fee-for-service payment for Medicare services plus monthly management fee per enrollee; shared savings for payers and physicians	Per-member, per-month care coordination payment, increase in fee-for-service rates, or access to savings	Fee-for-service payments or bundled payment for all services (Medicare Parts A and B) in a clinical episode	Fee-for-service for initial length of arrangement; Pioneer program includes partial population-based payment Shared savings, and may participate in shared losses
Physician Impact				
Varies depending on scope of awarded projects	Primary care physician financial incentives for patient management initiatives, and on-site care manager	Centralizes referral and care communications with primary care physicians	Requires cooperation with specialists and ancillary caregivers to enact episode-based payment methodology	Strengthens primary care by providing incentive to focus on disease and care management May create incentive for use of medical home Requires active physician participation to lead cost reduction and meet quality standards

Table 3. CMS Integration and Payment Reform Programs (cont.)

HEALTH CARE INNOVATION CHALLENGE	COMPREHENSIVE PRIMARY CARE INITIATIVE	FQHC ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION	BUNDLED PAYMENTS FOR CARE IMPROVEMENT	ACO (PIONEER AND SSP)
Degree of Physician-Hospital Integration Required				
Likely encourages physician alignment via service delivery or payment innovations that support patient care coordination	None required	Infrastructure requirements, such as electronic health records, may drive formal integration	Requires coordination, but not necessarily formal integration, although integration makes it easier	May require formal integrated structure depending on bundled payment model selected
Implementation Challenges				
Must be self-sustaining following the initial grant period (three years)	Largely dependent on payer to implement programs that impact Medicare fee-for-service and commercial patient populations	Capital requirements for information technology Does not create incentives for specialists, hospitals, or other providers to participate in care coordination Requires care model redesign, which may be difficult to accomplish	Hospital typically assumes majority of downside financial risk Discount thresholds may be unachievable for some hospitals	Large capital investments may be needed for infrastructure; data mining and management resources required Confusion over patient attribution (patients do not "select" to be in an ACO, but are "attributed" based on their use of primary care services) Potential for financial losses
Cost Improvement Opportunity				
Projects required to lower total costs of care to qualify for funds Varies depending on scope of awarded projects	Reduces costs through decreased ER visits and decreased inpatient utilization Low to moderate impact depending on the initiatives implemented by payer	Reduces costs through decreased ER visits and lower inpatient utilization	Expects discounts greater than 3% on usual Medicare fees Does not address frequency of cases	Reduced costs, decreased ER visits, and decreased inpatient utilization
Benefit to Patients				
Improved care coordination Proactive health management	Improved communication and more efficient coordination of care Proactive health management	Improved care coordination and access to providers Proactive health management	Defined clinical pathways expedite patient care and lead to more consistent outcomes Provider must meet quality guidelines	Improved care coordination Proactive health management

Source: The Camden Group.

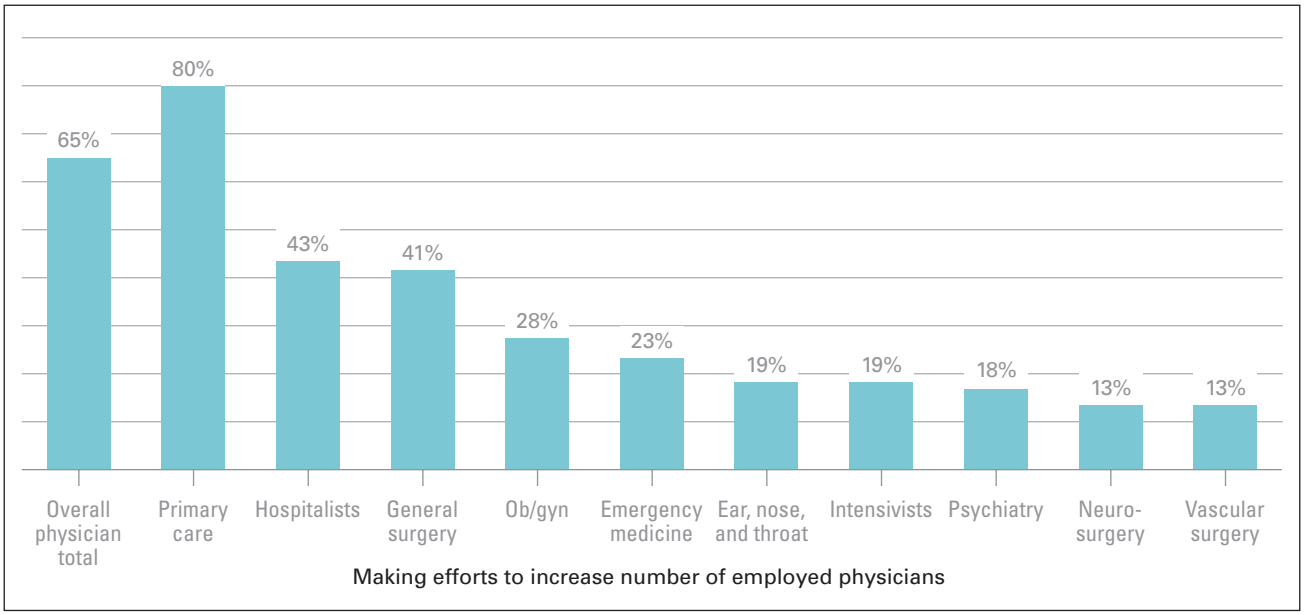
V. Impact of Health Care Reform on Physician-Hospital Integration

Physicians Seek Opportunities to Integrate

The ACA and other recent national initiatives to improve health care quality and efficiency, primary care and specialist workforce shortages, diminishing financial performance, and competitive pressures have combined to compel hospitals to initiate or expand existing aligned medical staff structures. California prohibits direct employment of physicians by entities other than professional corporations in most cases, so many hospitals and health systems use medical foundations, as well as other models, as a mechanism for formal alignment. Nationally, the American Hospital Association reported that 65% of hospitals surveyed in 2010 planned to increase the number of employed physicians in the upcoming year.[33] (See Figure 2.) For details and analysis of medical foundation activity in California, see the 2010 report *Physician-Hospital Integration in the Era of Health Reform*, published by the California HealthCare Foundation.[34]

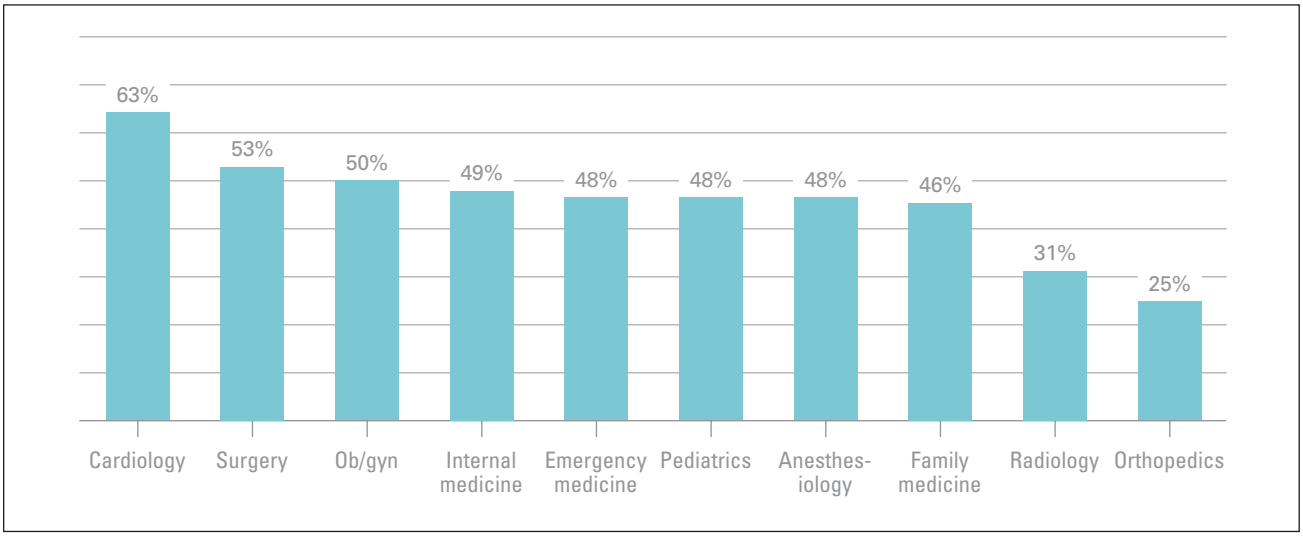
Similarly, regulatory, quality, and financial realities have driven physicians — in particular, solo practitioners and specialty groups — to seek alignment opportunities in increasing numbers. Physician interest in employment, as well as other alignment structures, is strong, with more than 50% of cardiology, surgery, and obstetrics/gynecology (ob/gyn) specialists expressing interest in hospital employment in a recent national study.[35] (See Figure 3.)

Figure 2. Hospitals Increasing the Number of Employed Physicians, National, 2010



Source: American Hospital Association, *Rapid Response Survey: Telling the Hospital Story* (March 2010).

Figure 3. Physician Interest in Employment, by Specialty, National, 2010

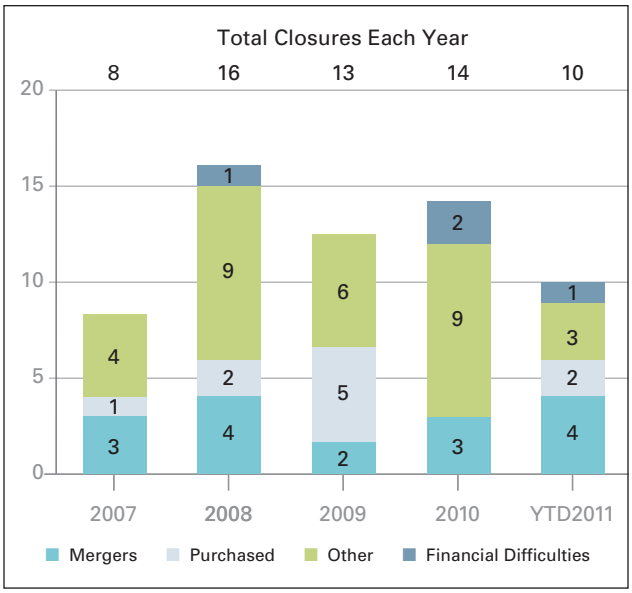


Source: PricewaterhouseCoopers Health Research Institute, *Physician Survey* (2010).

Accelerating Consolidation Activity in California

As a result of economic pressures and expected future capital obligations, some small- to medium-size physician groups have sought to merge or close their practices. Industry association and senior hospital leaders interviewed for this paper noted a marked increase in the number of physician organizations that have approached hospitals, health systems, and other medical groups with alignment proposals. Frequently, these physicians seek to participate in the organization's medical foundation or other integrated structure, such as an outpatient clinic, to merge with an existing medical group, or to work in an alternative shared-risk arrangement. The majority of executives interviewed for this paper hold the view that physician practices will continue the trend of pursuing integration, particularly as a means of limiting their exposure to financial risk.

Figure 4. Physician Practice Closure Activity, California, 2007-2011



Note: "Other" closure explanation includes small enrollment, ceased HMO contracting, no reason given, and other. Closures listed for 2011 include activities through November 1, 2011.

Source: Cattaneo & Stroud, List of Closed Medical Groups, *Report 2A* (2011).

Data bears out the view that, across California in recent years, mergers and acquisitions of medical groups have become more frequent. Between 2008 and 2011, 53 medical groups in the state closed, merged, or were purchased. (See Figure 4.) Among recent transactions, large independent practice associations, medical foundations, and academic practices have been consolidating to increase market presence and to position themselves for impending CMS and commercial integration models. (See Table 4.)

The Evolving Role of Payers

In an effort to effectively manage claims expenses, many payers have sought out new ways to influence physician practice decisions. In some instances, this has meant exploring ACOs or other shared-risk models with provider organizations. In other cases, payers have actually acquired physician organizations or invested in their management companies.

Among insurers with significant membership enrollment in California, UnitedHealth Group and Wellpoint, which operates Anthem Blue Cross of California, have each announced acquisition strategies to form stronger relationships with physician practices. Although California state law prohibits direct employment of

Table 4. Major Physician Practice Acquisitions, California, 2010-2011

ACQUIRED PHYSICIAN PRACTICE	ACQUIRING ORGANIZATION	PHYSICIANS IN ACQUIRED PRACTICE	ACQUIRED PRACTICE HMO ENROLLEES
Affiliated Doctors of Orange County	Heritage Provider Network	907	50,500
Alliance Physicians Medical Group	AppleCare Medical Group (Coast Healthcare Management)	173	15,900
Alta Bates Medical Group	Brown & Toland Physicians	610	46,500
Axminster Medical Group	Providence Medical Institute	136	27,800
Bay Area Community Medical Group	Santa Monica Bay Physicians Medical Group	320	38,200
Bristol Park Medical Group	Memorial Care Medical Foundation	687	74,900
Lakeside Community Healthcare	Heritage Provider Network	1,752	134,100
Mills-Peninsula Medical Group	Sutter Medical Foundations[a]	330	35,000
Northridge Medical Group	HealthCare Partners	305	27,200
Pacific Alliance Medical Group	AltaMed-Clinica Medica San Miguel	201	1,000
Physicians Integrated Medical Group	Hill Physicians	250	14,800
Santa Monica Bay Physicians Medical Group	UCLA Medical Group (UCLA–Santa Monica Bay Physicians)	40	-[b]
Talbert Medical Group	HealthCare Partners	379	66,000

(a) The medical groups that comprise the panel of Sutter Medical Foundation are: Sutter East Bay Medical Foundation, Sutter Gould Medical Foundation, Sutter Medical Foundation–Central Division, Sutter Medical Foundation–Central Division/Sutter West, Sutter Medical Foundation–West Division/Solano Regional, Sutter Pacific Medical Foundation, and Palo Alto Medical Foundation.

(b) Number of covered enrollees not available.

Note: Includes announced and completed transactions.

Source: Cattaneo & Stroud, *Report 2A* (2010).

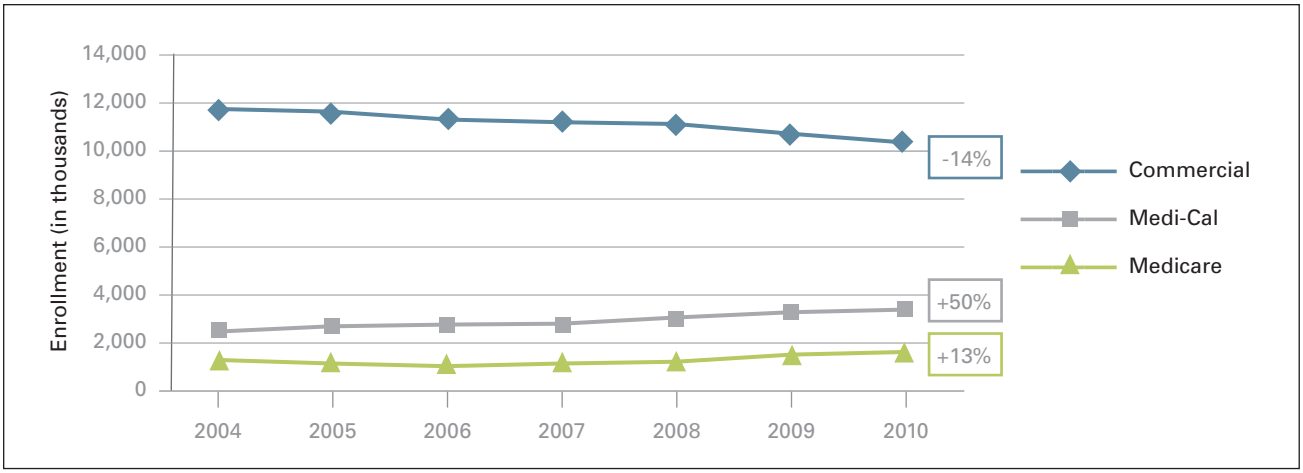
physicians by most entities, a payer can effectively control an independent practice association (IPA) by purchasing the IPA's non-clinical assets and overseeing its management. In 2011, for example, Wellpoint completed the purchase of Southern California-based Medicare Advantage plan and medical group CareMore Health Group. Similarly, Optum, the health services unit of UnitedHealth Group, announced the purchase of Monarch HealthCare, an IPA with 2,300 physicians based in Orange County. In addition to Monarch, Optum has also recently assumed management responsibilities for two smaller IPAs in the state, AppleCare Medical Group and Memorial Healthcare IPA.[36]

In California, IPAs are of particular interest to payers due to the IPAs' extensive population-management experience. In addition, many IPAs and other medical groups have experienced growth constraints in recent years, in terms of both enrollment and access to capital, due to the decline in commercial HMO enrollment. (See Figure 5.) In such circumstances, an arrangement with a payer can be a viable means of securing access to capital.

Other payers have implemented different approaches to lowering costs and developing new revenue streams in response to the ACA. For example, Aetna has developed strategies to enable clinical integration and business model transitions for hospitals and physician groups nationwide. The company recently formed the Accountable Care Solutions unit, which will work with both contracted and non-contracted providers. The unit proposes to support physician-hospital alignment in three ways: new care and business models, such as payment models and private label health plans; consulting services; and tools and operating capabilities, such as advanced clinical decision-support technology, disease management, wellness programs, and traditional health plan underwriting and administration services.

Aetna views provider need for health information technology as a key strategic opportunity for health plans to expand the scope of services they can provide, in particular to fulfill the data-sharing and analytical needs of integrating providers. Aetna views some other strategies, such as reference pricing (in which beneficiaries are required to pay for any provider costs beyond the "reference" price) as less important. "Most organizations are still trying to figure out what to do," Charles Kennedy, MD, head of Aetna's Accountable Care Solutions unit, told researchers for this study. "There is a significant thirst for information about what other providers are doing, how they are doing it, and most importantly, why they are doing what they are doing."

Figure 5. California Medical Group HMO Enrollment, 2004-2010



Sources: Cattaneo & Stroud and The Camden Group.

Health plans are also experimenting with network and contracting strategies to drive down health care costs. Leaders interviewed for this study reported that the major payers are seeking to leverage narrow networks, tiered benefit plans, and other strategies to drive increasing cost transparency to members, hence encouraging the use of more cost-effective providers. Physician organizations and hospitals are often thrust together to respond to these strategies in order to preserve referral patterns, relationships, and market share. Blue Shield of California, for instance, is beginning to focus on bundled payment models, in addition to specialty "centers of excellence" and ACOs as levers for integration. Based on the success of Blue Shield's existing ACOs, the insurer plans on rolling out between five and eight additional accountable care provider initiatives in California in 2012.

An executive from a California health insurer noted that many plans are exploring ways to limit access to large, high-cost providers that dominate local markets. Many of these strategies, which seek to reduce excessive utilization and lower costs, bring together hospitals and physicians in new arrangements, such as bundled payments, ACOs, and other shared-risk structures to align incentives for reducing costs and achieving quality benchmarks.

Current Physician Integration Activity in California

Among providers in California, new models of care have not been uniformly embraced. Physicians and hospitals alike feel compelled to integrate, but the elements of integration — from the care management model and participating organizations to performance standards and financial incentives — vary widely between geographic regions and segments of providers. For instance, IPAs or medical groups with significant market presence and experience in managed care contracting have implemented strategies that largely circumvent hospital integration by forging direct, formal relationships with payers or other provider organizations. Further, a few leaders interviewed for this study noted that while some hospitals and physician organizations in the state have rapidly formed new, formal partnerships with each other, FQHCs, rural health clinics (RHC), and other safety-net providers have not been as quick to integrate.

Accountable Care Organizations in California

Based on anecdotal information gathered for this study, hospitals and physician groups across California are evaluating the feasibility of forming Medicare ACOs under the SSP. (For details about Medicare ACOs, see "Overview: CMS Accountable Care Programs" on page 10 of this report.) CMS is expected to announce the initial provider organizations participating in the SSP in Spring 2012.

As of December 2011, CMS announced that six provider organizations in the state will be participating in the Pioneer ACO program, beginning in 2012. (See Table 5.)

Table 5. California Providers in the CMS Pioneer ACO Program, 2012

ORGANIZATION	SERVICE AREA
Brown & Toland Physicians	San Francisco Bay Area
HealthCare Partners Medical Group	Los Angeles and Orange Counties
Heritage California ACO	Southern, Central, and Costal California
Monarch HealthCare	Orange County
PrimeCare Medical Network	San Bernardino and Riverside Counties
Sharp HealthCare	San Diego County

Source: Centers for Medicare & Medicaid Services, December 2011.

Compared to the caution with which organizations are approaching CMS's Medicare ACO programs, activity surrounding commercial ACOs has been more substantial, at least in some markets. Many partnerships between hospitals, medical groups, and payers integrate processes of care and leverage the payer's claims with the providers' electronic health records data to assess opportunities for care management improvement. Physicians and their hospital partners, in effect, adopt the role of an at-risk payer; financial responsibility for patients included in the ACO is shared or transitioned to the providers. In all, this model enables integration through local physician accountability, shared financial responsibility, and use of timely performance information. Early returns from the first commercial ACOs show promise: the California Public Employee Retirement System pilot ACO, formed in partnership with Hill Physicians, Dignity Health (formerly Catholic Healthcare West), and Blue Shield of California, reported a 14% drop in total patient days and a 17% reduction in 30-day readmissions. Estimates suggest that this ACO is likely to result in $15.5 million in total savings in its first year.[37]

In many markets outside of California, the vast majority of ACOs are led by hospitals or integrated delivery networks, in partnership with a local payer that has the resources to shift focus toward comprehensive population management. (For details on selected commercial ACOs across the United States, see Appendix B.) In California, the experience of IPAs and medical groups with HMO delegated risk (professional capitation) positions them well for taking leadership positions in commercial ACO products. Examples are HealthCare Partners and Sharp Community Medical Group in Anthem's ACO pilot. Aetna, Blue Shield of California, and Anthem Blue Cross have formed ACOs with integrated medical groups and IPAs. Many of these ACOs have expanded enrollment beyond traditional HMO members to include PPO members, in order to realize potential savings by steering patients to the most appropriate settings of care.[38] (For information regarding selected commercial ACOs operating in California, see Appendix C.)

Integration Efforts Among California Pediatric Providers

Integration activities among pediatric providers in the state have been less pronounced than those of their adult care counterparts. Numerous health care leaders interviewed for this study noted that the absence of pediatric provider participation guidelines for CMS programs has stalled integration activities. In particular, providers that serve predominantly pediatric Medi-Cal and Healthy Families program populations cannot participate in the SSP as it is currently defined, since it is focused on the traditional Medicare population.

The increasing proportion of patients insured by Medi-Cal, coupled with declining local government budgets, has increased the fragmentation of pediatric health care delivery. Primary care access deficiencies lead to children with serious medical conditions seeking treatment in high-cost sites of care, such as children's hospitals. Recently, these providers have increasingly come under pressure by payers to reduce costs. Further, slow adoption of information systems has hampered evaluation of service utilization, costs, and gaps in the continuum of care. In addition, the potential elimination of the State Children's Health Insurance Program and Disproportionate Hospital Share subsidies has made many providers cautious about changes to the existing care delivery model for fear of additional budgetary shocks.

Medi-Cal is a significant source of payment for most children's hospitals, and with Medi-Cal budgets at continuing risk of annual reduction, groups of children's hospitals have joined forces to assess the applicability of accountable care models for the pediatric population. In 2011, the California Children's Hospital Association began evaluating the potential for a statewide children's pediatric ACO or specialty health plan, with the goal of developing an integrated model of care in which primary care physicians and preventative care providers would work in close clinical and economic relationships with children's hospitals. Results from this assessment were not publicly available at the time of this publication.

Leaders interviewed for this study were skeptical about the application of the ACO model to children's hospital care delivery. Many children's hospitals lose money on pediatric cases insured by Medi-Cal or the Healthy Families program. While interview participants agreed that there are inefficiencies likely across the continuum of pediatric care, the ability of the ACO model to effectively reduce costs in children's hospitals is untested. According to Cindy Ehnes, president and CEO of the California Children's Hospital Association, children's hospitals see the sickest patients, many of whom require extensive inpatient care. Typically, ACOs leverage primary care physicians to achieve quality and cost improvement by keeping patients out of the hospital, a strategy that may not be effective for children's hospitals that treat non-chronic, highly acute patient populations.

On the other hand, the need to manage the care of patients for whom lifelong attention is necessary, in order to follow up on congenital or other complex conditions, may create opportunities for ACO-like initiatives. For example, pediatric community providers are taking steps to use the patient-centered medical home model as a means of fostering integration among clinicians, hospitals, county health plans, and local agencies. During the first half of 2012, children's hospitals, county providers, and health plans in five counties will participate in a regional pilot program to test the effectiveness of various integration models in overcoming barriers to providing multidisciplinary care for children with special needs.[39] (See Table 6.) Under the pilot, a pediatric ACO in San Diego County, to be initiated by Rady Children's Hospital, will coordinate care for 600 children who have one of three chronic conditions: cystic fibrosis, hemophilia, or sickle cell anemia. The Rady pediatric ACO hopes to improve

Table 6. California Children's Services (CCS) Regional Pilot Program, 2012

COUNTY	LEADING ORGANIZATION	INTEGRATION MODEL	PARTICIPATING ORGANIZATIONS
Alameda County	Alameda County Health Care	• Medical home • Care coordination and managed through EHR linkages	• Physicians, specialists, hospitals, and other programs
Los Angeles County	LA Care Health Plan	• Medical homes for each participating acute care provider • Eventual transition to county-wide CCS system of care for eligible children	• Three children's hospitals
Orange County	Children's Hospital of Orange County (CHOC)	• Medical home • Eventually transition into a specialty-specific ACO	• Specialty care centers • CHOC • CHOC community clinic • CHOC-affiliated physicians
San Diego County	Rady Children's Hospital of San Diego County	• ACO	• County CCS program • Rady • Rady-affiliated physicians
San Mateo County	San Mateo County Health Care	• Operational improvement and care management	• Existing managed care system • County CCS program • Primary care and specialty physicians

Source: California Department of Health Care Services.

care coordination for patients insured by Medi-Cal managed care plans who seek specialty care. Such care is reimbursed for qualified children under fee-for-service arrangements by California Children's Services, a program administered by the California Department of Health Care Services, which provides care management services for children with chronic conditions and infectious diseases.[40] Based on the outcomes from these initial pilots, the program may be rolled out across the state.

Integration Efforts by California Safety-Net Providers

Prior to the ACA, the complexity and economic challenges of California's health care safety net impeded integration efforts. The landscape of safety-net providers — FQHCs, RHCs, and physicians and other providers that accept patients regardless of their ability to pay — crosses geographic and political boundaries, making clinical partnerships difficult. Now, encouraged by newly available funding from both federal and state sources, provider organizations and county health services departments are evaluating integrated partnerships. To date, many of these emerging arrangements have focused on transitions in care, improved referral communication, and overall patient management.

Among these integrated delivery and ACO-like models beginning to emerge is the Accountable Care Network (ACN), a partnership in the Los Angeles region that is bringing together hospitals, FQHCs, and IPAs. Participating organizations include AltaMed Health Services Corporation, Citrus Valley Health Partners, Hollywood Presbyterian Medical Center, and White Memorial Medical Center. Thus far the ACN has focused on defining a physician-led approach to improving communications and patient hand-offs among the participating providers.

A number of individuals interviewed for this study noted that safety-net integration efforts have been slow to take shape due to structural, capital, and competitive issues. Since the payment system for community clinics is one in which all reasonable costs of care for visits are covered, providers lack incentive to pursue efficiency and utilization initiatives. In addition, California does not require reporting of specific quality measures at the clinic or individual physician level, and overall quality reporting is limited.[41] Updating the payment method to incorporate a performance-based approach would accelerate integration activities in the future, according to these sources.

Lack of funding for information technology, care navigators, and other tools to enable better care coordination has limited integration progress among safety-net providers. Expanded funding for infrastructure development through California's Bridge to Reform legislation will improve matters somewhat, with support for county clinics, public hospitals, and other local government health service programs. Other funds have also been made available, such as the Medicare FQHC medical home demonstration, which made awards to nearly 70 FQHCs in California to implement population-focused care management initiatives. These programs will encourage further consideration of integration activities among providers who serve safety-net populations.

To support the efforts of safety-net organizations and other types of providers, CMMI launched the Health Care Innovation Challenge, a grant program to provide $1 billion for public and private care improvement initiatives focused on high risk/high need populations nationwide. The program will begin in 2012, and will provide subsidies to projects for a three-year period.

It should be noted that questions regarding the competitive implications of integration have yet to be resolved. Geopolitical and organizational boundaries have slowed the ability of counties, nonprofit clinics, and other providers to form close partnerships due to concern about the budgetary impact of changing patient referral patterns. In particular, county hospitals stand to lose inpatient volume as a consequence of stronger primary care-based health initiatives. Initiatives aimed at increasing efficiency that, as a byproduct, reduce inpatient admissions are of lower priority to these organizations, as these changes have a direct impact on patient revenues and their bottom lines.

VI. Integration Case Studies: Six California Provider Organizations

Introduction

The following case studies describe how six different provider organizations in California are approaching physician-hospital integration in light of health care reform. These organizations represent different geographic areas across the state and different care delivery models, and are in different stages of development toward accountable care or other population-based payment models. (See Table 7.)

The providers highlighted in these case studies typify the diversity of health care markets across California, and the breadth of variation in local physician orientation to integration, competition among providers, and strategic opportunities and challenges in each market. While a few of the providers profiled operate in a single region, three of the organizations must integrate the resource needs, competitive challenges, physician culture, and other elements of multiple geographies, communities, or hospitals.

Table 7. Case Study Provider Organizations

PRESBYTERIAN INTERCOMMUNITY HOSPITAL	UCSF MEDICAL CENTER	ADVENTIST HEALTH	SCRIPPS HEALTH	ARROWHEAD REGIONAL MEDICAL CENTER	JOHN MUIR HEALTH
County					
Los Angeles	San Francisco	Multiple in Northern, Central, and Southern California, including Los Angeles, Kern, Kings, Mendocino, Napa, Tuolumne, Ventura, and Butte	San Diego	San Bernardino	Contra Costa
Metropolitan Areas					
Suburban	Urban	Urban, suburban, rural	Urban, Suburban	Suburban	Suburban
Organization Type					
Nonprofit community hospital and medical foundation	Academic medical center (hospitals and faculty practice medical group)	Health system (community hospitals, critical access hospitals, RHCs, and medical foundation)	Nonprofit integrated delivery system (hospitals, clinics, outpatient centers, and medical foundation)	County-owned hospital	Nonprofit integrated delivery system (community hospitals, clinics, and outpatient centers)

Source: The Camden Group.

These particular organizations are not offered as representing the full spectrum of organizational response to health care reform or physician-hospital integration. However, these organizations do illustrate the types of changes, organizational evolution, and competitive responses that are being addressed in communities across the state.

Presbyterian Intercommunity Hospital: Integration Brings New Challenges and Opportunities

In recent years, economic conditions in Presbyterian Intercommunity Hospital's (PIH) primary service area have eroded the hospital's financial performance, creating the need for more effective methods of cost management. According to 2010 U.S. Census estimates, communities that PIH serves, including Whittier, Hacienda Heights, Norwalk, and Pico Rivera, are predominantly Latino and have lower incomes compared to Los Angeles County as a whole and to the state. As of October 2011, the unemployment rates in PIH's nearby community of West Whittier Los Nietos was 13.5%, higher than the Los Angeles County unemployment rate of 11.9% and California's overall unemployment rate of 11.7% during the same month.[42] PIH has seen the amount of its bad debt burden (i.e., patient revenues that cannot be collected due to inability or unwillingness to pay) rise substantially in recent years as a byproduct of the poor economy. To add to PIH's financial challenges, Kaiser Permanente, which operates hospitals and clinics within PIH's service area, has recently been "more aggressive in advertising than ever before" according to PIH leaders, efforts aimed particularly at the commercially insured population.

Provider Profile: Presbyterian Intercommunity Hospital (Whittier, CA)

A nonprofit, freestanding acute care hospital, PIH serves a population of 1.5 million in its service area. The hospital's mission is to provide high quality health care without discrimination, and to contribute to the health and well-being of the communities it serves in an ethical, safe, and fiscally prudent manner in recognition of its charitable purpose.

Key Statistics

- Number of beds: 444
- Annual volume (self-reported): 17,475 discharges, 321,682 outpatient visits, and 69,145 emergency department visits
- Clinical services offered:
  - Oncology — cancer program, radiation therapy
  - Cardiovascular — cardiac catheterization laboratory, cardiac surgery, vascular intervention
  - Emergency care
  - Home health and hospice
  - Radiology, nuclear medicine — CT Scans, SPECT, MRI, IMRT, CTA, MRA therapies
  - Rehabilitation services
  - Intensive care — intensive care unit, neonatal intensive care

Physician Organization

- Medical staff: Between 550 and 600 physicians
- Physician composition: aligned with Bright Health Group, a medical foundation composed of approximately 150 primary care and 206 specialty physicians; the remaining physicians with hospital privileges are physicians in independent and solo practice

Effect of Payer Control over Provider Groups

In addition, management takeovers of physician practices by payers in the local market have added a sense of confusion and uncertainty to the competitive landscape. Some of these changes have had a positive financial impact on PIH. For example, PIH has experienced higher patient volumes, which hospital leaders attribute to changes that payers have made to their local contracting strategies. PIH believes that some payers are favoring physicians in its networks instead of groups purchased by other payers. Specifically, the acquisition of AppleCare Medical Group by United Healthcare's Optum division has pushed competing health plans to change their referral arrangements. Following the announcement, BlueShield of California and Anthem Blue Cross have directed patients away from AppleCare, referring patients to PIH's Bright

Health Group. While this is a positive development for PIH, the impact of the 2011 acquisition of CareMore Health Group by Wellpoint has yet to be played out within PIH's market. CareMore operates physician clinics in PIH's service area and has a long term contractual arrangement with PIH, but hospital executives interviewed for this study noted that the effect of this change remains to be seen.

Increasing Strength of Its Medical Foundation

Other trends have yielded additional opportunities and challenges for PIH. Independent physicians have been reluctant to join medical foundations, but many of these physicians are beginning to see employment in a foundation as a viable and welcome alternative to independent practice. Bright Health Physicians, the hospital's medical foundation, is the result of a merger of Bright Medical Associates and Presbyterian Health Physicians in 2008. The foundation has grown to more than 150 primary care and 206 specialty physicians. Recent foundation growth has been due, in part, to independent specialty physicians who increasingly appear to see economic benefit in joining a well-positioned medical foundation.

With regard to foundation growth, the hospital plans on leveraging its managed care experience to change the behavior of independent physicians. Historically, these physicians have been less aware of the impact of their practice patterns on overall patient care costs due to fee-for-service contracting arrangements. The PIH community has been dominated by small, independent physician practices that typically are skeptical of control by larger physician groups or hospital–physician integration structures such as medical foundations. As the marketplace consolidates around them, however, the economic security of being part of a larger medical group and hospital system has compelled a growing number of physicians to reevaluate the medical group-foundation model. The advantages of economic security and relevance in the market have begun to outweigh the autonomy and self-determination that come with a small independent practice.

Structural Changes to Cultivate Physician Leadership

In the four years since the creation of its medical foundation, PIH has developed mechanisms and initiatives to cultivate physician leadership within the foundation and across the hospital's medical staff. For instance, PIH changed its clinical service management structure to give physicians direct responsibility for clinical strategy and operations. It also instituted strategic business units to allow joint management of clinical service lines. In these, a physician, medical director, and designated hospital administrator serve as the co-chairs of a committee that oversees a clinical business unit, such as orthopedics. Decision-making for the units includes representation from the independent physician community, primary care physicians, and physicians of Bright Health. This broad participation encourages increased communication, collaboration, and awareness around issues related to patient hand-offs and ongoing post-discharge care management.

ACOs and Other Integration Activity

Although PIH leaders have followed the traditional California medical foundation model as their main physician alignment vehicle, the hospital is selectively pursuing other alignment models with its independent medical staff. These initiatives seek to provide alternatives for the independent medical staff while addressing some concerns about financial feasibility. The organization has opted not to pursue creation of a Medicare ACO through CMS, at least for the time being. And while the hospital has had conversations with some commercial PPO payers about an accountable care concept, PIH does not have formal plans to launch an ACO.

Bright Health physicians have always incorporated the Triple Aim™ and value-based purchasing frameworks into their initiatives, but progress in this regard with independent physicians in the community has been slower. According to William Stimmler, MD, president of Bright Health Group, physicians will become frustrated with the additional administrative and clinical requirements of health care reform. While he believes his group is already functioning as an ACO with PIH, at some point in the future it will partner directly with its most important health plans. Dr. Stimmler indicated that overcoming the current prevailing culture of physicians within the foundation and in the community is a potential roadblock for future integration plans with PIH.

In an effort to demonstrate that effective care can be provided via alternate payment models and delivery arrangements, PIH has plans to develop significant physician engagement and leadership integration activities. The hospital plans on applying for the CMMI Bundled Payment for Care Improvement Initiative for cardiac and orthopedic services, to start in fiscal year 2013. To enable connectivity and knowledge-sharing, electronic health records (EHR) will be deployed in all physician practices in 2012. In addition, the hospital has included members of the medical staff in the development and implementation of the hospital's strategic plan.

University of California, San Francisco (UCSF) Medical Center: Forming New Partnerships While Focusing on Patient Access and Quality

Despite its relatively small geographic size, the San Francisco Bay Area is a crowded, dynamic environment for health care providers, dominated by large physician practice organizations and regional health systems. In the face of declining reimbursements, numerous provider organizations broke existing partnerships or formed new alliances after the passage of the ACA. The securing of patient volume played an important role in these changes, as many organizations sought to lock in referral relationships in preparation for anticipated economic conditions. Brown & Toland Physicians (Brown & Toland), an IPA with more than 850 physicians at the time in the San Francisco area, changed UCSF faculty from in-network to a referral agreement in 2009.[43] Later, Brown & Toland acquired Alta Bates Medical Group, partnering with Sutter Health medical foundations. In turn, UCSF aligned with Hill Physicians and with a hospital partner, Dignity Health (formerly Catholic Healthcare West), which operates facilities in the city of San Francisco and San Mateo County. Today, UCSF and Brown & Toland maintain a loose relationship for adult and pediatric referrals.

Across the market, tough economic conditions have also driven physicians into larger provider organizations and regional payer initiatives, such as commercial ACOs and narrow provider networks. Further, Kaiser Permanente's strong presence in the region means that fewer commercially insured patients are seen by other providers, affecting those other providers' payer mix and financial performance.

UCSF executives interviewed for this study noted that providers across the region are uncertain about their future ability to deliver care in light of the regulatory requirements and economic conditions they now face. Although UCSF's academic practice model has fostered an impressive clinical reputation and patient quality track record, the ongoing national discussion about health care costs has focused the organization on opportunities to reduce avoidable admissions and to improve patient access and management. In all, UCSF's leadership team believes that in order to succeed in the coming years, providers need to overcome the historical culture of medical practice, look for alignment opportunities with competitors, and embrace new payment models. "We are at the end of an era in terms of how we've made money," said Mark Laret, CEO of UCSF Medical Center and UCSF Benioff Children's Hospital. He indicated that, while many providers rushed to partner or merge with other organizations in the year following passage of the ACA, it appears that leaders of hospitals, health systems, and physician practices are now taking a more methodical approach to evaluating future partnership opportunities.

Provider Profile: University of California, San Francisco (UCSF) Medical Center (San Francisco, CA)

UCSF Medical Center operates with about 7,000 employees on two campuses, with a third scheduled to open in 2014.

Key Statistics

- Number of beds: 600 hospital beds at Parnassus campus and 90 hospital beds at Mount Zion campus
- Annual volume (OSHPD 2010 and self-reported):
  - Parnassus campus: 25,171 discharges, 33,640 emergency department visits
  - Mount Zion campus: 3,602 discharges, 0 emergency department visits
  - Approximately 805,000 outpatient visits (combined campuses)
- Locations:
  - UCSF Medical Center at Parnassus
- UCSF Benioff Children's Hospital
  - UCSF Medical Center at Mount Zion
  - UCSF Medical Center at Mission Bay (under construction, opening planned for 2014)
- Clinical services offered:
  - UCSF Transplant Center, new in 2010, intended to serve 3,000 patients in its first year
  - UCSF Helen Diller Comprehensive Cancer Center — oncology services
  - Orthopaedic Institute, opened in 2009 in Mission Bay

Physician Organization

In addition to physicians in UCSF Medical School faculty practice, the medical center works with the following physicians:

- UCSF Primary Care
  - Eight primary care clinics that offer services in family medicine, internal medicine, women's health primary care, and weight management care
  - One Medical Group, affiliation with UCSF specialty referrals
- Hill Physicians
  - Recent partnership with Hill Physicians to provide primary and specialty care to the Northern California region community

ACOs and Other Integration Activity

UCSF does not anticipate participating in Medicare accountable care programs in 2012. The organization plans to build on its experience with its commercial payer bundled payment arrangements for orthopedic services by applying for Model 4 of the Medicare bundled payment initiative in early 2012. In March 2011, UCSF launched a commercial ACO to coordinate care for 6,000 San Francisco city and county employees. According to a joint press release, the initiative brings UCSF together with Hill Physicians Medical Group and Dignity Health facilities, St. Mary's Medical Center, Saint Francis Memorial Hospital, and Blue Shield to reduce emergency department and inpatient care costs. Patients will be encouraged to use primary care physicians from USCF, Hill Physicians, and Dignity Health for preventative care and non-emergency health care needs. The group believes this will drive efficiencies by reducing unnecessary emergency room visits, admissions, and readmissions.

In addition, UCSF is evaluating ways to best position itself amidst the diversity of large health care providers in Northern California. Although UCSF has a reputation as one of the world's leading centers for patient care, the organization seeks to further distinguish its market position from Sutter Health and Kaiser by improving its cost position. Dubbed the "Third Way" strategy, the health system has teamed up with health plans Blue Shield and HealthNet, and with Dignity Health and Hill Physicians, to evaluate the development of a new provider network.

Internal System Initiatives

To reduce appointment wait times for primary care physicians, the health system recruited a new medical director, established UCSF Primary Care on its Mount Zion campus, and opened clinics around the Bay Area. Physicians in the primary care group are not obligated to perform teaching and research, freeing them to dedicate more of their time to patient care. In addition, the health system is exploring the medical home concept to be deployed through its network of primary care clinics.

Clinical infrastructure investments are anticipated to significantly improve UCSF's ability to document, monitor, analyze, and identify best practices among physicians throughout the organization. As of late 2011, 75% of UCSF's community practices had EHR systems; UCSF hospitals are expected to come online in 2012. UCSF leaders anticipate that improved data collection and access will allow the organization to better assess clinical practice outliers and will help determine whether these variations had an impact on clinical outcomes. UCSF leaders noted that, while the organization has achieved high performance on quality and safety standards, the use of EHR will enable greater focus on individual physician performance.

Across UCSF, medical directors are responsible for establishing and meeting patient safety and quality goals. To date, these goals have focused on specific clinical initiatives, such as hand hygiene and reduction in hospital-acquired infections. Programs that target breakdowns in the care continuum, such as emergency room visits and avoidable readmissions, are starting to come into focus. UCSF's faculty practice physicians have shown some reluctance to embrace the organization's renewed interest in primary care and prevention. Although such initiatives improve community health, they also divert faculty physician attention away from clinical research and teaching, which are key attributes of the academic faculty practice model.

Adventist Health: On the Road to Physician Leadership

With its broad network of hospitals, outpatient clinics, rural clinics, home health agencies, and physician networks, Adventist's leadership team is cultivating a flexible approach to physician-hospital integration that varies among each of its major regions in California. Various opportunities to develop integrated relationships with physicians exist in Adventist's rural and urban markets, based on differences in its existing relationships with physicians, number of competitors in the market, and number of patients in the community.

In addition, Adventist system leadership has developed internal management structures and processes to foster physician leadership and engagement at each facility within the health system. System leaders indicated that the company has implemented initiatives to encourage physician collaboration within and among facilities, in hopes that leaders will share ways of breaking down barriers toward care improvement and accelerating the change process.

ACOs and Other Integration Activity

In 2010, the system created a medical foundation, the Adventist Physicians Health Network (APHN), to consolidate affiliated physician groups that operate throughout California. The group currently consists of over 60 physicians, with plans to expand in the years ahead. AHPN allows Adventist to have greater physician alignment and provides a vehicle for physician-hospital integration and consolidated managed care contracts. In less populated areas, such as Kings County, Adventist operates rural health clinics staffed with primary care physicians. In addition, Adventist contracts with physician groups to administer services at hospital outpatient clinics, known as 1206(d) clinics under the California Health and Safety Code. Clinics operating under this statute are licensed hospital entities.

The health system's experience with managed care contracting and patient management varies from region to region. Overall, Adventist leaders interviewed for this study indicated that the collapse of physician practice management companies and hospital performance with capitation in the past has discouraged the system from pursuing population health management strategies on a larger scale. At the time of the interviews, Adventist's leadership team did not have plans to pursue applications for the CMS accountable care programs. However, the company received a grant from Blue Shield to develop a commercial ACO with Adventist Medical Center – Hanford and two other markets,

Provider Profile: Adventist Health (Roseville, CA)

Adventist Health is a faith-based, nonprofit, integrated health care delivery system that operates 18 hospitals, 14 home health care agencies, and more than 130 outpatient centers and rural health clinics across California, Hawaii, Oregon, and Washington.

In California, the system operates facilities in three regions with vast differences in population size, demographics, and location: the Central Valley, Northern California, and Southern California (greater Los Angeles area). Given the geographic diversity of its service areas, Adventist acute care hospitals, rural health clinics, and home health agencies are supported by a medical care foundation and independent affiliated physician groups.

Key Statistics

- Central California — Three critical access hospitals and one general acute care hospital serve communities within Kings County, Tuolumne County, and south Fresno County:
  - Central Valley General Hospital, Hanford (49 beds, full service, NICU, clinics)
  - Adventist Medical Center, Hanford (142 beds, new full-service hospital opening in 2012)
  - Selma Community Hospital, Selma (57 beds, rural hospital)
  - Sonora Regional Medical Center, Sonora (152 beds)
  - Adventist Medical Center, Reedley (formerly Sierra Kings District Hospital) (44 beds)
- Northern California — Adventist Health has several rural/suburban hospitals within its network in Northern California (north of the Bay Area), with six Adventist Health hospitals and one behavioral health center within Mendocino County, Napa County, and Butte County:
  - Feather River Hospital, Paradise (101 beds)
  - Frank R. Howard Memorial Hospital, Willits (25 beds)
  - Saint Helena Hospital Region, St. Helena (151 beds)
  - Saint Helena Hospital, Clear Lake (25 beds)
  - Saint Helena Hospital Center for Behavioral Health (61 beds)
  - Ukiah Valley Medical Center, Ukiah (78 beds)
- Southern California — Adventist Health provides health care services in suburban and urban settings within Kern, Ventura, and Los Angeles Counties.
  - San Joaquin Community Hospital, Bakersfield (255 beds)
  - Simi Valley Hospital, Simi Valley (201 beds)
  - White Memorial Medical Center, Los Angeles (354 beds)
  - Glendale Adventist Medical Center, Glendale (457 beds)

Physician Organization

- Adventist Health Community Care is a network of clinics that provides general and specialty medicine throughout Kings, Fresno, and Tulare Counties. Each of these clinics has a team of physicians that provides multi-disciplinary care to the communities they serve.
- Adventist Health Physicians Network (AHPN) is a newly created medical foundation composed of multi-specialty physician practices.

among other commercial ACO opportunities. In addition, various hospitals in the system are pursuing the Bundled Payment for Care Improvement Initiative for orthopedic and cardiac services. With its extensive network of primary care physicians that supports its 35 rural health clinics throughout California, the system has not ruled out Medicare ACO plans in the future.

Adventist's cautious approach toward ACOs appears to be based, in part, on the recognition among its leaders that proper resources need to be in place to make any accountable care arrangement successful. "If we get into population management, we need the infrastructure to sufficiently manage risk," reported Mark Ashlock, senior vice president of physician and network strategy for Adventist Health.

Internal System Initiatives

Recognizing that individual facilities and physicians are responsible for the health of their communities, Adventist's system leadership has implemented programs and initiatives with the goals of increased quality of care and patient safety. Reduction in physician practice variation has become a key area of focus for medical executive leadership. Within each facility, "micro-systems" of physician practices and processes exist, and understanding differences in treatment patterns among clinicians within each hospital and across the system is a priority, said Keith Doram, MD, vice president of clinical effectiveness and chief medical officer at Adventist Health. "Our challenge has been: How do we drive clinical performance across the different types of provider environments in the system?"

The system has leveraged information technology as a tool to gather and assess quality and safety data. The system began deploying inpatient EHR in 2002 and has begun to deploy EHR in its outpatient clinics with an ultimate goal of a seamless information technology platform across all sites of care. With these tools coming online, the system is exploring evidence-based medicine practices, including deployment of physician order sets, to improve their ability to effectively manage patients. According to Dr. Doram, the goal is to ensure that every facility has an order set for each major patient population. Clinical information management and real-time analysis are critical components of the system's future success. To steer these efforts, in late 2010 Adventist recruited Steve Margolis, MD, to lead clinical informatics for the system as assistant vice president and chief medical information officer.

To ensure that physicians play an active role in the development and execution of patient-centered care and quality improvement processes, Adventist instituted a matrix physician leadership structure. A corporate medical executive committee, composed of the chief medical officers and the vice presidents of medical affairs for each facility in the system, is used to enhance dialogue between clinicians at the corporate and local levels. Physicians from across the system may participate in non-clinical management training to develop key leadership skills. Physicians also participate in ongoing system forums to advance department, service line, and other initiative-specific goals. A system performance council is in place, which encompasses the clinical, strategic, financial, and capital plans to strengthen the connection between clinical performance and the company's overall targets and performance.

Scripps Health: Building a Population Health Care Delivery System

Scripps Health, a nonprofit integrated delivery system, views the current state of provider economics as an opportunity to enhance its population health management capabilities and care delivery network. In both areas of change, system leaders believe physicians play crucial roles. "No matter what form that health care reform takes, we know that there's far less money coming from the government to pay for care," said June Komar, corporate executive vice president of strategy and administration at Scripps Health. "To manage with lower reimbursement, we need to have a fully engaged group of physicians to identify best practices, areas to reduce inappropriate variation, and areas to deliver better value."

The system is based in San Diego County, where the provider landscape is marked by relatively high HMO enrollment, high quality health care providers, and highly competitive provider organizations. Large provider organizations, which include Sharp HealthCare, University of California, San Diego, Rady Children's Hospital San Diego, and Kaiser Permanente, operate facilities in the county. Although enrollment in managed care health plans in the county is significant, Scripps' volume of HMO patients is relatively small compared to Sharp's and that of other area providers.

Provider Profile: Scripps Health (San Diego, CA)

Scripps Health is an integrated delivery system composed of five acute care hospital campuses and 23 outpatient centers and clinics throughout San Diego County.

Key Statistics

- Number of beds: 1,409
- Annual volume (combined OSHPD 2010 and self-reported): 75,207 discharges, 2,028,323 outpatient visits, 165,058 emergency department visits
- Scripps Health inpatient facilities are located on five campuses throughout San Diego county:
  - Scripps Green Hospital, La Jolla
  - Scripps Memorial Hospital Encinitas, Encinitas
  - Scripps Memorial Hospital La Jolla, La Jolla
  - Scripps Mercy Hospital (two campuses), San Diego and Chula Vista
- Outpatient Centers (23 clinics)

Physician Organization

- Medical Foundation
  - Scripps Coastal Medical Group (141 primary care physicians, 9 specialists)
  - Scripps Clinic Medical Group (82 primary care physicians, 440 specialists)
- Affiliated Physician Groups
  - Connect the Docs Multi-Specialty Network (165 primary care physicians, 149 specialists)
  - Mercy Physicians Medical Group (77 primary care physicians, 291 specialists)
  - San Diego Physicians Medical Group (100 primary care physicians, 300 specialists)
  - XiMED Medical Group (22 primary care physicians, 206 specialists)
  - Scripps Mercy Physician Partners Medical Group (64 primary care physicians, 192 specialists)
  - Primary Care Associates Medical Group (55 primary care physicians)

Integration Activities

The proportion of managed care enrollment in the area contributes to competitive pressures: Managed care contracts depress reimbursement rates, so providers become more focused on market share as a means of maintaining financial viability. In addition, leaders from Scripps Health interviewed for this study indicated that, while the hospital landscape has been relatively stable in San Diego in recent years, physician groups in the region have been increasingly interested in formal hospital and health system affiliations. For Scripps, this has taken the form of mergers with Scripps medical groups through its medical foundation and the creation of a physician-hospital contracting organization for participation in emerging health reform models.

While the ACA propelled integration considerations to the forefront of Scripps' strategic considerations, the health system had already made a number of changes over the last decade to more closely align sites of care with clinical practitioners. Two groups that are part of its medical foundation, Scripps Coastal Medical Group (composed mostly of primary care physicians) and Scripps Clinic Medical Group (composed of multi-specialty physicians), ensure clinical coverage and access to care throughout San Diego's urban and outlying suburban areas.

Internal System Initiatives

Scripps' five hospital campuses and affiliated medical groups historically were organized and operated in clinical silos. In 2011, Scripps leaders implemented a matrixed systems management structure coupled with system-wide physician co-management. In this model, physician leadership teams work with system administrators to identify and drive clinical workflow improvement across the continuum of care for the system as a whole. Additional teams manage service lines within each hospital. While the creation of these structures was a departure from the system's previously decentralized system of care, physicians embraced the change. "When we talked about horizontal management across the care environment, the doctors got it right away," said Komar. Within each

hospital there were some managers who, accustomed to site-specific processes and reporting relationships, experienced difficulty adjusting to the new practices, which included more shared data reporting, collaborative decision-making, and implementation of system best practices for quality clinical care and cost management. Despite the difficulties to be expected with any significant change, Scripps Health reported dramatic savings within the first year.

To help Scripps and its affiliated medical groups prepare for and implement contracting and care delivery models initiated by the federal government and private insurers, the parties created ScrippsCare. A California nonprofit mutual benefit corporation, ScrippsCare members include Mercy Physicians Medical Group, Connect the Docs Multi-Specialty Network, Scripps Mercy Physician Partners, Primary Care Associates Medical Group, Scripps Clinic Medical Group, Scripps Coastal Medical Group, and XiMED Medical Group, in addition to Scripps Health. In a joint venture, Scripps and North American Medical Management are developing the infrastructure to respond to and support alternative care management arrangements of ScrippsCare. ScrippsCare is also planning on participating in bundled payment programs in 2012, and is evaluating how best to incorporate and implement medical home and ACO development opportunities into its future strategic direction.

Arrowhead Regional Medical Center: Improving Its Care Delivery System

As a public hospital owned and operated by San Bernardino County, Arrowhead Regional Medical Center (ARMC) faces the challenge of serving a large population of patients who have limited resources: At 12.1%, unemployment in the county is among the highest in California, and more than 75% of ARMC's patients are uninsured or covered by Medi-Cal plans, a number that has grown as a result of recent economic conditions. At the same time, emergency department visits have increased since 2008, and hospital administrators report a marked increase in patient volumes during the last fiscal year. As a consequence, ARMC has struggled with increasing bad debt. The organization is also preparing to deal with even more patients in the years ahead, as implementation of the ACA will increase the number of patients insured by both Medi-Cal and commercial health plans, most likely at coverage levels consistent with those generally accepted by safety-net providers.

Provider Profile: Arrowhead Regional Medical Center (Colton, CA)

ARMC is a 456-bed teaching hospital that serves San Bernardino County and surrounding communities. As one of the few certified primary stroke centers in the region, ARMC offers the community a much needed resource for reducing disability and death associated with stroke.

Key Statistics

- Number of beds: 456
- Annual volume (OSHPD 2010 and self-reported): 23,971 discharges; 260,600 outpatient visits, 148,269 emergency department visits
- Clinical services offered:
  - Level I primary stroke center
  - 24-hour emergency department (Level II trauma center)
  - Burn center serving San Bernardino, Riverside, Inyo, and Mono Counties
  - Adult and neonatal intensive care units
  - An outpatient facility that offers 60 different specialty services, including pediatrics, orthopedics, internal medicine, women's health, rehabilitation services, and geriatrics
- Family Health Centers:
  - ARMC has three family health centers (clinics) throughout the county. These clinics offer primary medical services, ob/gyn, pediatrics, and geriatric care.
  - Locations include:
    Arrowhead Fontana, Fontana
    Arrowhead McKee, San Bernardino
    Arrowhead Westside, San Bernardino

Delivery System Reform

Since ARMC's patient population is primarily uninsured or covered by Medi-Cal, physician-hospital integration initiatives touted by CMS and commercial payers have had little impact on the hospital. However, California's new Medi-Cal 1115 Waiver, also known as the Bridge to Reform program, focuses the attention of public hospitals such as ARMC on goals similar to those of the IHI Triple Aim™.[44] (See "California's Bridge to Reform Program: An Overview," below.)

California's Bridge to Reform Program: An Overview

The Bridge to Reform program allows patients who would become eligible for Medi-Cal coverage or commercial insurance subsidies in 2014 to get a head start by accessing coverage starting in 2011-2012 through the Low Income Health Program (LIHP). The program supports comprehensive, coordinated care for vulnerable populations by moving them into Medi-Cal managed care plans. LIHP also tests various strategies for strengthening and transforming the public hospital delivery system in order to help prepare state agencies and providers for increased health plan enrollment when health care reform laws are fully implemented in 2014.

To facilitate these goals, the program established a Delivery System Reform Incentive Pool (DSRIP) to create incentives for efforts in four areas:

- Infrastructure development
- Innovation and redesign
- Population-focused improvement
- Urgent improvement in care

Leaders at ARMC interviewed for this study indicated that it is especially important for the organization to aggressively move toward reforming its delivery system. Due to competitive dynamics specific to its service area, ARMC leaders expect other health care providers in the community to have little interest in serving newly insured patient populations when insurance expansion occurs in 2014. ARMC sees its role as a safety-net provider for San Bernardino County continuing for the foreseeable future. Reimbursement rates for these groups are expected to be at Medi-Cal levels, which typically do not cover patient care costs. As a result, ARMC believes competing providers in its local market will focus on aggressively increasing market shares for commercially insured patient populations. Retooling its care delivery model to more efficiently deliver patient care will help alleviate the anticipated operational strains.

Care Model Redesign

To prepare for higher patient volumes, ARMC is undertaking a two-pronged approach. The county has implemented ArrowCare, its Low Income Health Program (LIHP) , effective January 1, 2012. ARMC will administer ArrowCare, which leverages ARMC clinics, physicians, and inpatient and outpatient services as primary caregivers. The program has also established relationships with independent physicians throughout San Bernardino County to serve this population. In conjunction with its Delivery System Reform Incentive Payments (DSRIP) program efforts (see below), ARMC is also embarking on a major care model redesign process during 2012 by improving access and implementing patient-centered medical home and chronic care initiatives in its three primary care clinics. ARMC leaders anticipate that care model redesign will facilitate better care coordination, improve quality for patients with chronic disease, and decrease costs over time. They also believe these efforts will decrease emergency department utilization, especially for patients with chronic diseases and multiple comorbidities. ArrowCare intends to work further with its contracted physicians to spread these care process tenets into their practices.

At the same time, ARMC is actively working to accomplish its DSRIP initiatives. In addition to the primary care redesign initiatives discussed above, other areas of focus include the following DSRIP-funded expansion projects during the next five years:

- Expansion of its family medicine and internal medicine residency programs by six residents
- Strengthening of its chronic disease management through implementation of a disease registry
- Expansion of its specialty care capacity by developing best practice clinical guidelines that delineate the roles, services, and referral processes provided by primary care and specialty physicians for high referral clinical conditions

Given its unique position as the county's major safety-net provider, ARMC leaders indicated that there has been little interest on the part of other local providers in forming collaborative relationships. Instead, ARMC anticipates that other providers will seek to maximize Medicare and commercially insured patient volumes. ARMC has a strong working relationship with Inland Empire Health Plan (IEHP), the primary Medi-Cal managed care plan in the county, and expects their joint endeavors to expand over time. ARMC has contracted with IEHP to administer provider credentialing for the ArrowCare program.

ARMC administrators describe its working relationships with its medical staff as one of collaboration. While many public hospitals employ their physicians, as authorized by Section 1206 of the California Health and Safety Code, ARMC made the decision many years ago to contract with independent community physicians to serve its patients. This arrangement allows more flexibility for the organization in meeting the specialty needs of its patients because it provides a mechanism for accessing physicians who are not required on a full-time basis. The major disadvantage to this approach is that it is not always easy to expand coverage if demand grows, because the contracted physician group may not have the required additional capacity. Because the contract model has worked well for ARMC, leaders do not have plans to move to an employed medical staff model.

As ARMC focuses more intently on efficiency, quality, and the patient experience, it recognizes that it will have to more actively involve its medical staff in day-to-day decision-making to achieve its DSRIP goals and to more effectively manage patient-related costs. ARMC's medical director has served as the focal point for these initiatives within the organization, and the organization is considering ways to further involve the medical staff in planning and ongoing management of hospital services.

John Muir Health: Evolutionary Change to Adapt to Changing Payment Models

For the past 15 years, John Muir Health (JMH) has focused on managing growth through expanding its primary care network, enhancing relationships with independent specialists, and investing in resources that improve clinical services and facilities. Also during that time, features of the system's culture and operational focus have evolved, according to those interviewed for this study. That evolution has created an environment that the system leaders believe better positions it for adopting new payment models, such as ACOs, that require a population-based approach to patient management.

Located in the competitive East Bay in Northern California, JMH competes with highly integrated systems such as Kaiser Permanente and Sutter Health. Hill Physicians, an IPA acclaimed for its early success with Blue Shield's ACO in the Sacramento market, also operates in JMH's service area. While operating in a mature managed care environment is not new to the JMH system or its physicians (the system's medical foundation, John Muir Physician Network, takes professional fee capitation in its arrangements with HMOs), system leadership is preparing for a future where the vast majority of its total revenue will likely include some form of population-based patient revenue.

Provider Profile: John Muir Health (Walnut Creek, CA)

JMH serves the suburban communities of Concord and Walnut Creek in the San Francisco Bay Area, and operates as a nonprofit integrated system of physicians, hospitals, and other services. JMH has two of the largest medical centers in Contra Costa County and also operates a behavioral health center.

Key Statistics

Facilities:

- John Muir Medical Center — Walnut Creek (Walnut Creek, CA). Serves as Contra Costa County's only designated trauma center
  - Number of beds: 330
  - Annual volume (OSHPD 2010 and self-reported): 17,310 discharges, 70,600 outpatient visits; 44,069 emergency department visits
- John Muir Medical Center — Concord (Concord, CA). A Magnet hospital. In November 2010, opened the Hofmann Family Patient Care Tower providing 12 cardiovascular ICU beds as well as 39 private telemetry rooms
  - Number of beds: 254
  - Annual volume (OSHPD 2010 and self-reported): 9,003 discharges, 28,000 outpatient visits, 41,918 emergency department visits
- John Muir Behavioral Health Center (Concord, CA). Offers complete inpatient and outpatient behavioral health programs for its 73-bed psychiatric hospital located in Concord
  - Number of beds: 73
  - Annual volume (OSHPD 2010): 2,792 discharges

Physician Organization

- John Muir Physician Network (900 affiliated physicians). Operates 24 locations throughout Contra Costa County and parts of Alameda County:
  - John Muir Medical Group (more than 100 primary care physicians, nurse practitioners, and physician assistants, combined), operates four urgent care centers in Contra Costa County
  - Muir Medical Group, IPA (more than 200 independent primary care physicians and over 600 specialists)

Evolving Internal Systems

JMH's management team has increased the organization's focus on reducing costs, adhering to evidence-based protocols, exploring alternative payment and delivery models, and positioning for continued growth. JMH leaders recognize that active involvement of physicians at all levels is critical to achieving success in these areas. For the first time, JMH is recruiting for a newly created system chief medical officer to coordinate clinical improvement initiatives across its continuum of care. More than 400 clinicians were involved in the selection of both physician and hospital EHR systems. Michael Kern, MD, senior vice president and medical director of the John Muir Physician Network, has witnessed the organization's shift in the managed care arena and notes that recent years have brought "a greater focus on integrating efficiency with quality."

Several specific initiatives demonstrate the system's push for evolving its operating, financial, and clinical models. A patient-centered medical home has been piloted by 12 physicians at a practice site operated by the John Muir Physician Network and John Muir Medical Group. The results of this pilot are consistent with those in other parts of the country: Admissions decreased in JMH hospitals, and higher levels of physician and patient satisfaction were reported. The system's practices with a high proportion of Medicare patients, many of whom have complex chronic conditions, will be the focus of this medical home project. With greater patient and physician engagement in proactively managing chronic diseases, the John Muir Physician Network expects to roll out the medical home model in additional practices over the next few years; Dr. Kern expects that over 50% of the foundation's patients will be managed via a medical home practice model by 2015.

Reducing readmission rates is a focus of many hospitals. In 2012, Medicare will begin penalizing hospitals for high readmission rates for heart failure, heart attack, and pneumonia patients. In preparation for this change, in 2010 JMH instituted an interdisciplinary forum composed of hospitalists, independent cardiologists, hospital case managers, primary care physicians, and other members of the hospital team. The forum is charged with identifying process and care improvements to reduce readmissions. To date, this effort has resulted in a 5% reduction in the readmission rate for heart failure patients. One of these care improvements is a Care Transitions Team that facilitates patients' care from the hospital to home. Another is a telemedicine program that has helped heart failure and chronic obstructive pulmonary disease patients stay connected with clinicians, who monitor their answers to key questions daily via a website.

ACOs and Other Integration Activity

Similar to other provider organizations in California, JMH is evaluating participation in the Medicare SSP. In the meantime, it continues to leverage its experience with managing risk in Medicare Advantage as a springboard to effectively deliver cost-effective care to Medicare fee-for-service patients. Paul Swenson, chief executive officer of the medical foundation and executive vice president of JMH (at the time of the interviews for this study), noted that commercial health plans are actively sharing ideas for ACO-like initiatives, which the JMH system is also evaluating. In this regard, JMH has agreed to participate with Blue Shield in its ACO initiative.[45] JMH has established an ACO Steering Committee, co-chaired by leaders of its medical group and IPA, to determine the organization's future direction with accountable care efforts.

The challenge for making these initiatives successful, as noted by the John Muir leaders interviewed for this paper, is ensuring access to good quality data. Although independent physicians, foundation physicians, and the hospitals are all implementing EHR, each is implementing a different platform, with limited interconnectivity and ability to share information in real time. The organization hopes that implementing particular information technology tools through the vendor Medventive, along with other initiatives, will enable greater interconnectivity and thus will better support population management and quality reporting across the continuum of care.

To evolve into a truly integrated delivery system, JMH must face challenges related to patient care coordination and medical management. Mr. Swenson noted the need to invest in initiatives, such as efforts to reduce length-of-stay or increase case management resources. However, these could result in reduced inpatient volume and thus a drop in revenue, or require additional investment, which would run counter to most organizations' need to demonstrate a positive "net present value" for such initiatives. Without strong financial performance and a long term perspective, it would be difficult for provider organizations to make these investments, limiting their ability to adapt to the post-reform environment.

JMH also needs to establish structures and decision-making processes that engage independent physicians, who still make up the majority of physicians in JMH's market. "How do we give independent physicians greater authority and involvement in decisions within the integrated delivery system?" Mr. Swenson queried. During the last 15 years, the governance structures within John Muir Medical Group and Muir Medical Group IPA have transformed the culture from "a group of individuals that didn't really know each other" to one that can determine strategy and make immediate, difficult financial and operating decisions. Leaders are contemplating ways that independent physicians and foundation physicians alike can engage in the system's evolution to population-based payment systems.

Comparison of Case Study Alignment Structures

While the providers described in the preceding case studies operate in different markets, serve different patient populations, and have different clinical operational challenges, some key commonalities exist with respect to how they are integrating with physicians. (For a side-by-side comparison, see Table 8.)

First, among the six hospitals and health systems profiled, only one — Arrowhead Regional Medical Center — does not have an established and aligned medical foundation, physician faculty practice, or employed medical staff. This is indicative of the move of acute care providers toward formalizing aligned, dedicated regional physician networks.

Further, to drive efficiency and quality improvements, the majority of these organizations are contemplating expanding integration with their aligned physician groups by developing physician leadership and management structures within their hospitals. Of the six organizations profiled, only two have yet to enact some form of physician leadership structure, and all the organizations are actively considering ways to enhance physician leadership.

Initiatives to improve medical management and non-fee-for-service payment arrangements were prominent among the providers highlighted in the case studies. Several organizations indicated that improving care coordination and management of HMO patients is another area of developmental focus. Nearly all of the providers included in the study indicated that they are pursuing bundled payment or medical home initiatives as a stepping stone toward the development of institutional medical management competencies. For many, CMS proposals for shared savings ACOs for Medicare patients are being considered, but not aggressively pursued at this time. It should be noted, however, that all of these organizations have managed care experience through HMO capitation arrangements in which their physicians participate, and many participate in shared-risk arrangements.

Table 8. Physician-Hospital Integration Characteristics, Case Study Organizations

PRESBYTERIAN INTERCOMMUNITY HOSPITAL	UCSF MEDICAL CENTER	ADVENTIST HEALTH	SCRIPPS HEALTH	ARROWHEAD REGIONAL MEDICAL CENTER	JOHN MUIR HEALTH
Organization Type					
Nonprofit community hospital and medical foundation	Academic medical center (hospitals, and faculty practice medical group)	Health system (community hospitals, critical access hospitals, RHCs, and medical foundation)	Nonprofit integrated delivery system (hospitals, clinics, outpatient centers, and medical foundation)	County-owned hospital	Nonprofit integrated delivery system (community hospitals, clinics, and outpatient centers)
Physician Alignment Structure					
Medical foundation	Academic faculty physician practice with medical group and community physician affiliations	Medical foundation	Medical foundation	Contracts with physicians	Medical foundation
Managed Care Patient Management Experience					
Leveraging managed care experience for future population management	Leveraging managed care experience for future population management	Development focus	Leveraging managed care experience for future population management	Development focus (care model redesign)	Leveraging managed care experience for future population management
Medicare/Medi-Cal Initiatives					
Bundled payment ACO (commercial populations)	ACO (commercial populations) Bundled payment	ACO (considering commercial development) Bundled payment	Considering various initiatives	Patient-centered medical home in development	Patient-centered medical home pilot ACO (commercial populations)
Physician Leadership and Management					
Joint physician-administrator service line leadership with community physician representation	Academic faculty practice leadership structure	System-wide physician leadership structure ("matrix")	Joint physician-administrator service line leadership (system "matrix")	Developing physician leadership model	Developing physician leadership model

Source: The Camden Group.

VII. Conclusion

As more specifics regarding the implementation of health care reform legislation come to light, physicians and hospitals are shifting their positions with respect to integration. Even before ACA implementation regulations were developed, large provider organizations with strong delivery networks began expanding partnerships with other providers. Today, many providers of all types, serving varied populations, are evaluating how reform's mandates — quality excellence, population health management, efficiency, and cost savings — can be realized in light of economic, political, and market constraints. In many cases, organizations are taking a step-by-step approach to integration, experimenting with models and arrangements to build organizational competency and to determine the feasibility of broad adoption. The future landscape of care delivery in California will be shaped by these efforts.

Implications for Policymakers

While there are many benefits to be realized from physician-hospital integration, there are a number of matters that California policymakers will need to consider with respect to current trends.

Impact of Provider Consolidation on Pricing for Patient Services

Consolidation of provider organizations across the state could increase the price of patient services. As hospitals, medical groups, and other provider organizations form collaborative provider networks, such as ACOs, or merge with one another, patients will have fewer distinct choices from which to receive clinical care. When market consolidation has occurred in other industries, the remaining competitors have often leveraged their market power to increase prices. Within California's health care landscape, the net impact of increasing provider consolidation on pricing remains to be seen. It should be noted that the ultimate impact of provider consolidation may be mitigated by payers, who are stepping up pressure to reduce prices and increase transparency of cost and quality reporting for providers. In addition, the rollout of benefit models that encourage use of lower-cost providers may further dampen the market effects of partnerships and mergers.

Appropriate Patient Access to Clinical Services

Alignment of provider and payer incentives may reduce health care spending but may also have the unintended consequence of reducing access to needed medical services. Increased coordination of patient care and monitoring of quality and patient experience have the potential to bring significant improvement to how patients interact with their care providers and to the health status of communities. At the same time, pressures to reduce costs may limit the ability of patients to access certain medical services. Regulations requiring disclosure of health plan network performance around access to primary and specialty care will continue to be of great importance. Further, the actions of payers and providers in the coverage and management of clinical services will need to be monitored and evaluated to ensure that patients are not denied necessary care.

Effect of State Budget Cuts

Although California's Bridge to Reform waiver and other ACA-related programs have expanded funding for providers and patients, additional state budget cuts may limit the ability of providers to realize the goals of their integration efforts. Pediatric and safety-net providers, in particular, have withstood recent cuts in reimbursement but are vulnerable to future reductions. Today, many of these providers have begun to see increased demand due to rising Medi-Cal and Healthy Families enrollment, which is likely to be exacerbated in 2014 as eligibility for Medi-Cal and other subsidized insurance becomes available to a broader population. Many of these providers also lack the infrastructure and mechanisms necessary to successfully enable physician-hospital integration. Development and infrastructure planning at facilities that serve these populations is vulnerable to near-term changes in funding. Federal grants, such as those offered by CMMI through the Innovation Challenge, may provide avenues to jump start programs that will improve access to care for vulnerable patient populations.

Strain on Safety-net Providers from Increased Patient Demand

The expansion of insurance coverage to previously uninsured populations, plus the implementation of the California Health Benefit Exchange, could further strain the health care safety net throughout California. Growth of the insured population is likely increase operational stress on safety-net providers, such as FQHCs, RHCs, and public hospitals, who provide primary care services to uninsured and underinsured patients across the state. To date, these providers have not been able to meet patient demand, due to limitations in physician coverage and facility space. The 2011 introduction of state funding to address infrastructure constraints and development opportunities is expected to help address these issues, but other steps may need to be undertaken to ensure timely access to care.

Uncertainty for Safety-Net Providers Regarding Newly-insured Medi-Cal and Commercial Patient Populations

While some providers that serve safety-net populations are concerned about staffing shortages, others fear that these patients, once they are covered by richer health insurance benefits, will be referred to "mainstream" health care providers because of improved reimbursement. Should this come to pass, the financial impact on providers who serve uninsured and underinsured populations would be significant. While the magnitude of this issue will not be known until 2014, providers that serve the safety net should take steps to improve their care delivery and relationships with physicians through enhancing clinical, financial, and technological integration strategies. Initiatives underway as part of the Bridge to Reform are designed to facilitate these improvements, but whether or not they will be adequate or widespread enough is yet to be seen.

Appendix A

FQHC Advanced Primary Care Practice Demonstration Sites (Medicare Patients) in California

PRACTICE NAME	CALIFORNIA CITY
American Indian Health & Services Corporation	Santa Barbara
Asian Pacific Health Care Venture	Los Angeles
Borrego Community Health Foundation	Cathedral City
Borrego Community Health Foundation	El Cajon
Centro De Salud De La Comunidad De San Ysidro	Chula Vista
Centro De Salud De La Comunidad De San Ysidro	National City
Centro De Salud De La Comunidad De San Ysidro	San Diego
Chapa-De Indian Health Program	Auburn
Clinica Sierra Vista	Arvin
Clinica Sierra Vista	Bakersfield
Clinica Sierra Vista	Bakersfield
Clinica Sierra Vista	Fresno
Clinica Sierra Vista	Fresno
Clinica Sierra Vista	Lake Isabella
Clinica Sierra Vista	Lamont
Clinica Sierra Vista	Lebec
Clinica Sierra Vista	Wofford Heights
Clinicas De Salud Del Pueblo	Blythe
Clinicas De Salud Del Pueblo	Niland
Clinicas De Salud Del Pueblo	Winterhaven
Clinicas Del Camino Real	Oxnard
Clinicas Del Camino Real	Ventura
Community Health Centers Of The Central Coast	Cambria
Community Health Centers Of The Central Coast	Lompoc
Community Health Centers Of The Central Coast	Nipomo
Community Health Systems	Fallbrook
County Of Monterey	Salinas
Darin M. Camarena Health Center	Chowchilla
Fall River Valley Health Center	Fall River Mills
Golden Valley Health Center	Los Banos
Golden Valley Health Center	Planada
Golden Valley Health Centers	Modesto
Golden Valley Health Centers	Modesto
Hill Country Community Clinic	Round Mountain
Imperial Beach Community Clinic	Imperial Beach
LifeLong Medical Care	Oakland
Marin Community Clinic	Novato
Marin Community Clinic	San Rafael
Mendocino Community Health Clinic	Willits
National Health Services	Bakersfield
National Health Services	Wasco
Neighborhood Healthcare	Escondido
North East Medical Services	San Francisco
North East Medical Services	San Francisco
North East Medical Services	San Francisco
North East Medical Services	San Jose
Open Door Community Health Center	Arcata
Operation Samahan	National City
Operation Samahan	San Diego
Queenscare Family Clinics	Los Angeles
Queenscare Family Clinics	Los Angeles
Redwoods Rural Health Center	Redway
Salud Clinic	West Sacramento
Salud Para La Gente	Watsonville
Santa Barbara County County Auditor	Carpinteria
Santa Barbara County County Auditor	Santa Barbara
Shasta Community Health Center	Redding
Shasta Community Health Center	Shasta Lake
South Central Family Health Center	Los Angeles
United Health Centers of the San Joaquin Valley	Kerman
United Health Centers of the San Joaquin Valley	Orange Cove
United Health Centers of the San Joaquin Valley	Sanger
Valley Health Team	Kerman
Vista Community Clinic	Oceanside
Vista Community Clinic	Vista
Vista Community Clinic	Vista
West County Health Centers	Guerneville
West County Health Centers	Sebastopol
West Oakland Health Council	Oakland
Western Sierra Medical Clinic	Downieville

Source: CMMI

Appendix B

Commercial Accountable Care Organizations in the U.S., 2011 (Select)

PARTICIPATING PROVIDER(S)	PARTICIPATING PAYER(S)	STATE	STRUCTURE	PATIENT POPULATION	PHYSICIAN NETWORK	START DATE	PAYMENT MODEL
(Undisclosed)	Horizon Blue Cross Blue Shield of New Jersey	NJ	Medical group-payer	1,000 to 2,000 patients with commercial self-insured PPO coverage		4th Quarter 2010	Shared savings
Advocate Physician Partners (Advocate Health Care)	Blue Cross Blue Shield of Illinois	IL	Medical group-payer	Commercial PPO members in the greater Chicago area	2,700 (multi-specialty)	January 2011	Shared savings
Carilion Clinic	Aetna	VA	Integrated delivery system-payer	17,000 Carilion employees	600 (multi-specialty)	January 2012	Partnership / collaboration
Eastern Maine Medical Center and Blue Hill Memorial Hospital	CIGNA	ME	Hospital-payer	4,000 PPO, OAP, and network/ managed care members	50 Primary care physicians	January 2010	
Hackensack University Medical Center	QualCare	NJ	Hospital-managed care	13,200 insured employees		September 2011	PCP financial incentive risk
MaineGeneral Health Collaboration	Maine State Employees Health Commission (SEHC)	ME	Integrated delivery system-state employee commission	4,400 (In MaineGeneral self-insured population), 8,000 (SEHC insured population)	116 (primary), 112 (specialists)	February 2010	Risk-sharing FFS
Methodist HealthCare	CIGNA	TN	Hospital-payer	31,000 aligned CIGNA members (2,000 Methodist/ HealthChoice)	1,000 Physicians	June 2011	Partnership / collaboration
Montefiore Medical Center	Emblem-Health	NY	Hospital-payer	90,000 EmblemHealth members			FFS shared savings
Multiple Providers	Blue Cross Blue Shield of Massachusetts	MA	Payer- IPA, PHO, integrated system	Massachusetts BCBS members state-wide		January 2009	FFS, partial capitation, and shared savings (upside and downside risk)

Appendix B: Commercial Accountable Care Organizations in the U.S., 2011 (Select) (cont.)

PARTICIPATING PROVIDER(S)	PARTICIPATING PAYER(S)	STATE	STRUCTURE	PATIENT POPULATION	PHYSICIAN NETWORK	START DATE	PAYMENT MODEL
Norton Healthcare	Humana	KY	Integrated delivery system-payer	10,000 Norton and Humana market employees	2,000 (multi-specialty)	August 2010	Shared savings FFS
Piedmont Physicians Group	CIGNA	GA	IPA/medical group-payer	13,300 Aligned CIGNA members (3,100 Piedmont employees)	117 primary care physicians	June 2010	Pay-for-performance FFS plus Incentives
St. John's Mercy Medical Group	CIGNA	MO	IPA/medical group-payer	9,000 PPO, OAP, and network/ managed care members	160 primary care physicians	July 2010	
St. John Providence Health - The Physician Alliance		MI	IPA/medical group-hospital			Pending	In development
Tucson Medical Center	United Healthcare	AZ	Hospital-payer		75 (primary), 10 (medical specialty), 15 (surgical specialty)	January 2008	FFS Shared savings model

Source: ACO Learning Network, Beckers Hospital Review, Cigna, Inc., The Commonwealth Fund, Medical Health Plan, and Montefiore Medical Center.

Appendix C

Commercial Accountable Care Organizations in California, 2011 (Select)

PARTICIPATING PROVIDER(S)	PARTICIPATING PAYER(S)	STATE REGION	STRUCTURE	PATIENT POPULATION	PHYSICIAN NETWORK
Monarch Healthcare	OptumHealth-United HealthCare	Southern California (Greater Los Angeles Area)	IPA/medical group-payer	In development	2,300 (multi-specialty)
Healthcare Partners	Anthem (Wellpoint)	Southern California (Greater Los Angeles Area)	IPA/medical group-payer	42,000 Anthem PPO enrollees	1,000 (primary), 1,462 (medical specialty), 240 (surgical specialty)
CalPERS - Catholic Healthcare West, and Hill Physicians	Blue Shield of California	Northern California (Bay Area)	IPA/medical group-payer/ retirement system	40,000 CalPERS members	
Sharp HealthCare (Sharp Community Medical Group or Sharp Rees-Stealy Medical Centers)	Anthem (Wellpoint)	Southern California (Greater San Diego Area)	IPA/medical group-payer	17,000 eligible PPO members, 22,121 ACO participating members	Sharp Community Medical Group (700 primary and specialty physicians) Sharp Rees-Stealy Medical Centers (400 primary and specialty physicians)
Brown & Toland Physicians Group, and California Pacific Medical Center	Blue Shield of California	Northern California (Bay Area)	IPA/medical group/hospital - payer	21,000 members of San Francisco Health Service System	800 (multi-specialty)
Hill Physicians Medical Group, Catholic Healthcare West, and University of California San Francisco Medical Center	Blue Shield of California	Northern California (Bay Area)	IPA/medical group/hospital - payer	5,000 members of San Francisco Health Service System	
John Muir Health		Northern California (Bay Area)			
Hoag Memorial Hospital Presbyterian/ Greater Newport Physicians	TBD	Southern California	IPA/medical group/hospital - payer		Hoag Memorial Hospital Presbyterian (1,300 medical staff) Greater Newport Physicians (500 affiliated physicians)
South Los Angeles Safety Net ACO (Metro Care, MLK Hospital, St. Francis Medical Center, LA Care, California Hospital Medical Center)	N/A	Southern California (Greater Los Angeles Area)	Hospital network	5,000 initial enrolleees	
Individual Practice Association Medical Group of Santa Clara County	Anthem Blue Cross	Northern California (Bay Area)	IPA-Payer		284 primary care physicians, 550 specialists
Saint Joseph Health System	Blue Shield of California	Southern and Northern California	Health system-payer	30,000 Blue Shield HMO enrollees	Saint Joseph Hospital (1,000 medical staff), Saint Jude Medical Center (700 medical staff), Mission Hospital (700 medical staff)

Source: ACO Learning Network, Anthem Blue Cross, Blue Shield of California, CalPERS, Cattaneo & Stroud, National Health Foundation, Saint Joseph Health System, United Healthcare, Inc., and The Camden Group.

Endnotes

1. Leaders from the following organizations were interviewed as part of the research for this paper: California Children's Hospital Association, Contra Costa County, The Center for Studying Health System Change, San Mateo County, University of Southern California Keck School of Medicine, California Association of Public Hospitals, California Primary Care Association, BlueShield of California, Aetna, COPE Health Solutions, UCSF Medical Center, Presbyterian Intercommunity Hospital, Arrowhead Regional Medical Center, Adventist Health, Scripps Health, and John Muir Health.
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