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Commentary

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A Healthcare Provider's View of Progress on the Ground

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Some of the best minds in the state participated in the Berkeley Forum for Improving California's Healthcare Delivery System. As individuals and organizations, they have worked for decades to improve the quality, accessibility and affordability of care in California. In the Forum they worked to define initiatives that would be feasible, evidence-driven, reflective of the realities of California, and likely to substantially reduce healthcare expenditures in California. They laid out a series of recommendations that form a clear pathway to integrated care and more effective use of resources via risk-adjusted global budgets. For provider groups and health systems eager to assume more risk as a means to integrate and improve care, it was a clarion call.

Of the seven initiatives called for in the Forum Report, the first two – global budgets/integrated care systems and patient centered medical homes – promise the greatest leverage in transforming health systems and represent more than three-fourths of the total projected reductions in expenditures. Since the issuance of the report, however, the momentum of the market has swung ever more decisively against these recommendations. While Medi-Cal has steadily increased the proportion of beneficiaries in managed care, commercial enrollment in risk-based products has continued to fall, in large part because commercial HMOs have lost their price advantage and employers cannot get reliable cost and utilization data from capitated networks.

For providers, transforming healthcare has proven to be a slower and less certain task than they had expected. Instead of managing risk for populations,

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providers must continue to maintain financial solvency by pursuing volume-based strategies and cutting unit prices when necessary to remain in narrow networks. The path to integrating and improving health appears to have shifted to a new model: “commercial ACOs” that combine varying degrees of payment for care management with gain sharing for reductions in emergency department, hospital and skilled nursing facility utilization.

State government has focused on developing the Covered California insurance exchange and expanding and transforming Medi-Cal into a predominantly managed care insurance system. Covered California has arguably been the most successful early implementation of public exchanges in the country (Brumley et al. 2003), and with California’s several decades of experience in Medi-Cal managed care, has provided the state a strong foundation on which to base the expansion of Medi-Cal and the extension of managed care to the Medicare/Medi-Cal covered population. California has once again shown itself to be a national leader in developing comprehensive and effective programs to expand access to health insurance and health care.

A signal feature of the Covered California exchange, however, was its limited offerings of capitated products, made necessary by the exchange’s affordability targets and the difficulty of administering the higher deductibles for bronze and silver products in the context of capitation. It is worth noting that in several other states such as Massachusetts and Vermont, mandated global budgets and private health plan cooperation have led to public exchanges with predominantly managed care products.

A great deal will be learned over the next several years in California about enrollment and utilization patterns in the exchange and the efficacy of the provider networks, reimbursement systems, and structures for integration within exchange products. In effect, however, early expectations that California’s exchange would expand the role of delegated medical groups with managed care expertise were dashed, and medical groups and integrated systems have turned to new ACO-like partnerships with commercial insurers and self-funded employers in Preferred Provider Organization (PPO) products.

What potential is there for care innovation to occur in PPO contracting? To the extent that they enable more evidence-based care that supports patient engagement and self-management by providing reimbursement for care management and rewarding improved outcomes, such creative ways of using PPO plan design may establish the foundation for future care improvements. In fully capitated products (hospital and physician capitation), or even under partial capitation just entailing physician risk, the transformation of care was both necessary and rewarded. Will the incentives in these new PPO initiatives be strong enough to reform care?

The early results of commercial ACOs in California have been encouraging, moderating the expenditure trend by reducing utilization of expensive services. The most noted of these, the early ACO established by CalPERS with Blue Shield, Hill Physicians and Dignity Health, set out to achieve a zero-growth trend and out-performed even that ambitious goal – but was in fact an ACO-like arrangement for members enrolled in a partially-capitated Health Maintenance Organization product. Recent initiatives are set in PPO plans, and while it is still too early for conclusive results, several important observations can be made.

Commercial PPO-ACOs create an initial advantage for medical groups and health systems with previous experience in risk products and the infrastructure and experienced staff needed to manage care; to the extent that the commercial PPO-ACOs continue to grow, more providers will be encouraged to develop the necessary staff and infrastructure. Health plans are also motivated to share data with providers to an unprecedented extent, allowing providers to track patients out of network and to engage with health plan staff in on-going efforts to improve their management.

Providers are gaining experience empaneling patients in commercial PPO-ACOs and Medicare Shared Savings Program (MSSP) ACOs, and are able to compare their own performance in profiles offered by health plans and self-funded employers. Unlike fully capitated or professional fee risk contracts, however, the commercial PPO-ACOs and Medicare MSSP do not make capitated payments “up front,” depriving providers of an important source of funding for the costs of developing care management capabilities. The rapid aggregation of medical groups and health systems in California is therefore not only a pursuit of market leverage, but a response to the need for capital and capabilities for this transformation.

Ultimately these experiments will produce a variety of hybrids combining aspects of benefit design, network selection, provider and member incentives, and clinical care management. Several health plans worked actively with medical groups and integrated systems last year to establish an advocacy organization, the “Institute for Advanced Primary Care” in order to build the broader understanding, policies, and funding needed to produce new models and appropriately trained professionals. Although it did not succeed, its early efforts provided valuable insights.

Funding from the Centers for Medicare and Medicaid Services (CMS) and some variants of commercial PPO-ACO contracts have encouraged providers to build partnerships with community services providers for non-clinical functions that supplement clinical care and can produce substantial savings, such as the in-home palliative care program developed by Kaiser Permanente and shown to reduce net expenditures by more than one-third in a patient's last year of life (Scheffler and Foster 2014).

This is an extraordinary moment in the decades-long effort to expand access and transform the delivery of healthcare in California. Throughout the state, leader after leader will say – privately and in public – that this is the most exciting, exasperating, and promising period they have known. Yet the most important Berkeley Forum recommendation, for integrated care and capitation or global budgeting, was not actionable solely at the provider level. Employer-based commercial health plans and Covered California helped drive the growth of PPOs and particularly that of high deductible health plans, leaving providers who had anticipated managing risk “waiting at the altar.” They have gamely turned to experimenting with the new PPO-ACOs, but it will be several years before we know whether these innovations will be sturdy and resilient enough to genuinely transform healthcare.

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