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## Commentary

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# Increasing the Impact and Sustainability of California Accountable Care Organizations

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“A New Vision for California’s Healthcare System: Integrated Care with Aligned Financial Incentives,” the Berkeley Forum Report issued in 2013, addresses the fundamental issues that determine the quality and cost of health care in California. The Forum Report envisions a significant improvement in cost and quality if certain initiatives are implemented. This commentary addresses the Forum’s key initiative, which is to increase the number of people getting care from integrated systems that operate under risk-adjusted global budgets and the path to achieving 70% of enrollees receiving care under such systems.<sup>1</sup>

The initiative has two components – care provided by an *integrated system* and delivered for a *fixed payment*, i.e., a “global budget” under which costs are fixed regardless of the volume of services delivered. California has been a national leader in shifting financial risk to providers under fixed payments, specifically “capitation.” Multispecialty medical groups and some Independent Practice Associations (IPAs) have been delivering care under fixed payments since the mid-1980s.

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<sup>1</sup> The risk-adjust global budget/integrated care system initiative is one of seven initiatives modeled for cost-savings in the Berkeley Forum Report. In modeling the cost-savings, the “Forum Vision” assumed that 70% of Californians would receive care under this model by 2022. It is important to note that the broader Forum Vision goal is to increase the share of non-fee-for-service expenditures to 50% of total healthcare spending by 2022. To reach this goal, given that global budgets are often layered on top of a fee-for-service payment model, an even higher share of Californians would need to receive care provided under a risk-adjusted global budget. As such, 70% was selected as the assumption in modeling this initiative.

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Initially, medical groups and hospitals accepted a capitated payment for Medicare beneficiaries enrolled in what is now called Medicare Advantage. This method soon spread to include capitation for commercial members, although commercial capitation entailing both physician and hospital risk was rare before 2010. Many medical groups and IPAs suffered under the law of small numbers, finding it difficult to manage risk under the much lower per-member revenue granted by commercial contracts. However, with the creation of accountable care organizations (ACOs), we now see a revival of fixed payment for commercial enrollees. It can be argued this surge in commercial contracts for ACOs is fundamental to achieving the Forum's 70% target for this initiative.

California was an early adopter in the commercial ACO movement. One of the first and more prominent California ACOs involves the partnership of Blue Shield of California, Dignity Health hospitals, and Hill Physicians group. This ACO manages the Sacramento-based California Public Employees' Retirement System (CalPERS) members enrolled in Blue Shield insurance. The three-way partnership operates under a risk-adjusted global budget that puts all parties at financial risk (upside and downside). The results to date claim savings of \$110 million dollars for CALPERS.

This magnitude of savings could only have been realized under a global budget that includes two-way risk. As the Forum report documents, in its first year the Blue Shield arrangement generated savings of 8%. This more tightly integrated model and two-way risk encouraged all parties to institute care management protocols that assured quality, and derived meaningful savings well beyond what had been achieved previously.

Increasing the number of people getting care from well-managed ACO's operating under a global budget could achieve significant healthcare savings. To achieve the 70% goal, however, ACOs will have to significantly expanding their number and reach while also building and sustaining their results. Growth is a strategic imperative for plans and providers as they compete to create value for their employer group and individual customers, and is has been impressively strong since the writing of the Forum Report. Sustaining that success will depend on their establishing innovative mechanisms for care efficiency and population health.

Many California ACOs have attained that first level of performance. Anthem Blue Cross of CA, Blue Shield of CA and UnitedHealthcare have reported positive initial results. Moving to the second level of savings and quality, characterized by finding increased efficiencies and moving from process to outcomes based quality measures, remains the Holy Grail of ACO's.

Achieving this second level of performance will not be as easy, but it is reasonably clear what is needed to achieve it:

1. Technology infrastructure that allows data sharing across patients, providers and plans is critical. Disparate data systems require integration to support treatment protocol transparency, patient communication and decision support. The integration of actionable data is fundamental to achieving improved health and sustainable savings. All ACOs understand this imperative and are making efforts in this area. However, analysis that demonstrates the real return on investment of these efforts is required if we expect more effective data integration to occur. Big investments will not be made unless they are generated by persuasive cost-benefit analyses.
2. Physician leadership is crucial. As one Medical Director from a large California health plan said, “The single most important factor for an ACO to be successful is the quality of clinical leadership.” Programs to train clinical leaders in new models of care are emerging, but they will need to expand much faster to meet the growing need.
3. ACOs not only need to lower costs, they must improve the health of the population they manage. The basic tenets of population health are typically adopted by ACOs. Understanding population characteristics through health risk assessment and risk stratifying the population are common practice, and treatment of the chronically ill is receiving top priority, as it should.

However, maintaining a population’s health requires more. It should include the identification of “pre-chronic” patients whose reported biometrics or lifestyle habits call for early identification and, in many cases, early intervention to prevent the onset of chronic illness. This is especially true for commercial ACOs in which the average age is often 35–45. These enrollees can benefit by changing health and lifestyle habits to improve their current health and reduce costs in their midlife years.

Even the most sophisticated ACOs have not found a way to deploy resources cost-effectively toward this population. The results are hard to quantify, certainly in the short-term. Yet if we are to achieve health improvement at lower cost, more work will need to be devoted to finding methods to address this population.

Significant savings and quality produced by integrated systems (ACOs) incented through value-based payments are critical to achieving the Forum’s vision. Expanding the number of people receiving care through an ACO is already underway in California. The achievement of deep, sustainable results will remain a challenge unless ACOs are capable of further innovation in data integration, physician leadership, and population health management.