The Future of California’s Capitated-Delegated Physician Group Model

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Delegated Model Arrangements

Health Plan

Physician Group Network

Responsible for all medically necessary care and delegated functions

Non-Network Providers & Additional Services
Direct Model Arrangements

- Health Plan
- Medical Groups
- Ancillary Providers
- Hospitals & Facilities
- Individual Physicians

Diagram showing the connections between Health Plan and various providers and facilities.
Capitation

- Prepayment creates a prospective budget for patient care
- Responsible for all covered care needs
- Must be managed by the physician group to ensure sufficient resources exist to provide necessary care

Delegation

- Health plan administrative functions
- Downstream claims payment of other providers – ER, etc.
- Credentialing, network management, grievance
Risk Bearing Organizations (RBOs)

• Capitated & Delegated physician groups are classified as “risk bearing organizations”
• Knox Keene Act requires reporting and monitoring of all RBOs under statute and regulation
• RBOs are subject to indirect DMHC jurisdiction through their contracted health plans
• Enrollment can be frozen, they can be de-delegated, and DMHC can order termination of contract
Why Take Financial and Clinical Risk?

• Permits physicians to practice population health management in a flexible, innovative way

• Requires the physician group to organize care delivery based on best medical practices, identifying sub-groups of at-risk, chronic and highly-acute patients and coordinating their care to prevent further illness

• Providers make money based on their efficiency
## Risk Continuum

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Medium Risk</th>
<th>High Risk</th>
<th>Highest Risk</th>
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</thead>
<tbody>
<tr>
<td>MSSP Track 1</td>
<td>MSSP Track 2</td>
<td>Advanced Payment ACO</td>
<td>Global Risk</td>
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<tr>
<td>CPC+ Track 1</td>
<td>MSSP Track 3</td>
<td>Next Gen ACO</td>
<td>Provider-Sponsored Plan</td>
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<td></td>
<td></td>
<td>Medicare Advantage—Capitation model</td>
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<tr>
<td></td>
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<td>Professional risk</td>
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<td></td>
<td></td>
<td>Institutional risk</td>
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<tr>
<td><strong>Low Risk</strong></td>
<td><strong>Medium Risk</strong></td>
<td><strong>High Risk</strong></td>
<td><strong>Highest Risk</strong></td>
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<tr>
<td>Use clinical guidelines</td>
<td>Develop a disease registry</td>
<td>Determine DOFR</td>
<td>Manage credentialing process</td>
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<tr>
<td>Refer to preferred specialists, facilities, ancillary services</td>
<td>Develop strategies to manage high cost items</td>
<td>Contract directly with facility, ancillary, DME, provider services</td>
<td>Develop value-based contracting</td>
</tr>
<tr>
<td>Work on quality metrics</td>
<td>Develop CM team work flows to manage late stages of disease</td>
<td>Establish tiered network of providers, facilities, ancillary services</td>
<td>Develop process to accept Part D pharmacy risk</td>
</tr>
<tr>
<td>Develop CM team to manage episodic care</td>
<td>Report on disease specific cost of care</td>
<td>Manage utilization process—authorizations, denials, appeals</td>
<td>Obtain limited Knox-Keene license</td>
</tr>
<tr>
<td>Report on quality measures, patient attribution, cost of care</td>
<td>Develop education around proper documentation and coding</td>
<td>Develop repatriation process for out-of-network transfers</td>
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</tr>
<tr>
<td>Develop bonus structure for providers</td>
<td>Develop shared saving structure for other key stakeholders</td>
<td>Utilize predictive models for CM team to manage all levels of disease state</td>
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<td></td>
<td></td>
<td>Develop claims process to include audits of claims and payments</td>
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<td>Add stop-loss insurance</td>
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<td>Develop quality, appropriate utilization, citizenry dashboards for provider, facility, ancillary services</td>
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<tr>
<td></td>
<td></td>
<td>Develop bonus structure based on the dashboard</td>
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</table>
#1 - The Active California Medical Group Market  
as of March 15, 2017

<table>
<thead>
<tr>
<th>Active Medical Groups (1) by Type</th>
<th>All Groups Risk &amp; Non-Risk</th>
<th>Percent Distribution by Type</th>
<th>Estimated Enrollment for All Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Practices - All (including Kaiser)</td>
<td>41</td>
<td>13%</td>
<td>9,918,350</td>
</tr>
<tr>
<td>IPAs</td>
<td>137</td>
<td>43%</td>
<td>6,428,980</td>
</tr>
<tr>
<td>Foundations/Community Clinics</td>
<td>117</td>
<td>37%</td>
<td>3,282,000</td>
</tr>
<tr>
<td>Univ of Calif &amp; County Groups</td>
<td>22</td>
<td>7%</td>
<td>1,472,800</td>
</tr>
</tbody>
</table>

**TOTAL**  
317 | 100% | 20,102,100

Top 25 Active Medical Groups (All Types) (1)  
by Descending Order by HMO Enrollment

<table>
<thead>
<tr>
<th>Enrollment Range (2)(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Southern California Permanente Medical Group</td>
</tr>
<tr>
<td>2. Permanente Medical Group</td>
</tr>
<tr>
<td>3. HealthCare Partners Associates Medical Group</td>
</tr>
<tr>
<td>4. Heritage Provider Network</td>
</tr>
<tr>
<td>5. Employee Health Systems Medical Group (EHS)</td>
</tr>
<tr>
<td>6. Health Care LA, IPA</td>
</tr>
<tr>
<td>7. Los Angeles County Dept of Health Services</td>
</tr>
<tr>
<td>8. Vantage Medical Group</td>
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<tr>
<td>9. Hill Physicians Medical Group</td>
</tr>
</tbody>
</table>

Source: www.cattaneostroud.com
Medical Group performance by county

Medical Group Report Card for Commercial HMO Plan Members

There are 199 medical groups listed in the Medical Group Report Card. These medical groups have contracts with the commercial health plans listed in OPA’s HMO Report Card.

To see the clinical, patient experience and cost of care ratings in the Medical Group Report Card:

1. You can choose one of the 39 counties listed.
   There are 18 counties without any medical groups listed in the Report Card.
   Choose a county ▼

   or

2. You can choose the first letter of the medical group’s name.
   Choose a letter ▼

Related links
- About the Medical Group Ratings
- Directory of HMOs, PPOs, and Medical Groups
- What is a Medical Group?
- Integrated Healthcare Association (IHA)
- Pacific Business Group on Health

Link to Medical Group Reports
Proxy Data on Performance

California HMOs are largely organized around the capitated-delegated model in commercial and Medicare Advantage.

California PPOs are largely organized around, fragmented, directly-contracted networks of individual providers and facilities.

The Integrated Healthcare Association (IHA) posits that HMO and PPO performance data under their Regional Atlas serve as proxies for the two differing delivery systems – see the next 21 slides:
The Integrated Healthcare Association- a unique coalition

Founded in 1994, the Integrated Healthcare Association (IHA) is guided by a 40-member board of industry leading health plans, physician organizations, hospitals/health systems, purchasers, consumer groups, universities, and pharmaceutical and technology companies. We are committed to advancing high-quality, affordable, integrated, and patient-centered care.
IHA’s Atlas: highlighting quality and cost variation in CA

- **Measures:** Over two dozen standardized measures of clinical quality, total cost of care, patient cost sharing and utilization
- **Who’s Included:** 29 million Californians inclusive of commercial HMO, PPO, Medicare FFS, Medicare Advantage and Medicaid
- **What’s Viewable:** geographic and product line (including ACO) specific information
- **Collaborators:** California Health Care Foundation, California Health and Human Services Agency
- **Data Partners:** 10 health plans, CMS, Department of Health Care Service, Onpoint Health Data

https://atlas.iha.org

- **Measures:** 50 highly aligned measures of clinical quality, patient experience, utilization, total cost of care

- **Who’s Included:** Commercial HMO, commercial ACO, Medicare Advantage, Managed Medi-Cal (Medicaid) members

- **What’s Viewable:** Physician organization level performance data for commercial HMO and Medicare Advantage

- **Collaborators:** California Office of the Patient Advocate, National Committee for Quality Assurance, National Quality Forum, Pacific Business Group on Health

- **Data Partners:** 10+ health plans, 20 commercial ACOs, 200+ medical groups, independent physician associations & federally qualified health centers, Onpoint Health Data
Definition of Risk Types Used in IHA Analysis

• **No Risk (FFS)** – fee for service (FFS), no capitation

• **Professional Risk Only** – no facility capitation

• **Full Risk (two types)**
  
  • **Global Risk*** – single capitation contract with PO for both professional and facility
  
  • **Dual Risk*** – two separate capitation contracts for professional services (with PO) and facility services (with hospital or PO)

  *designation left to plans as part of data submission request

**NOTE:** California DMHC definition of “Risk Bearing Organization (RBO)” is a physician led organization with any level of financial risk sharing that pays claims
Degree of Risk Sharing Impact on Quality and Cost

Quality Composite Score by Risk Arrangement

- Average Clinical Quality Rate & Average Risk Adjusted TCC

Risk Adjusted TCC ($PMPY) -> WORSE

BETTER -> WORSE
First Finding: HMO products consistently outperform PPO products on Clinical Quality

- HMOs outperform PPOs by an average of 14 percentage points across ten measures
HMO Better Utilization

HMOs have lower all-cause readmissions than PPOs

HMOs have less commonly overused procedures than PPOs

Source: https://atlas.iha.org
PPOs Are Costlier

PPO are more costly than HMOs in 15 regions in CA

On average, PPOs are $383 PMPY more costly than HMOs

Source: https://atlas.iha.org
Member cost sharing $620 less on average for HMO than PPO in 2015

- $5.7 billion in OOP costs avoided by HMO members
Inpatient unit pricing contributes to higher total cost in Commercial PPOs.
First Conclusion: Commercial HMOs can provide higher value.
FFS Is Costlier

On average, FFS is $4540 PMPY more costly than MA throughout CA.
Consistent Story: Medicare Advantage outperforms FFS on clinical quality

• Even larger difference between Medicare Advantage (HMO) and Medicare FFS
Medicare Advantage costs strikingly lower than FFS, especially Southern California

- Medicare Advantage averages $13,572 per member per year compared to FFS at $18,112, a difference of $4,540.
MA Better Utilization

Medicare Advantage outperforms on ALL utilization measures

Source: https://atlas.iha.org
Member cost sharing $1,819 less for MA than Medicare FFS on average in 2015

- $3 billion in OOP costs avoided by Medicare Advantage members
Even Stronger Conclusion: more dramatic value for Medicare Advantage

<table>
<thead>
<tr>
<th>Medicare statewide average</th>
<th>Medicare Advantage</th>
<th>Medicare FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher quality, Lower cost</td>
<td>$11,000 - $21,000</td>
<td>$13,000 - $19,000</td>
</tr>
<tr>
<td>Lower quality, Higher cost</td>
<td>$15,000 - $17,000</td>
<td>$11,000 - $19,000</td>
</tr>
</tbody>
</table>

WORSE <= Risk Adjusted Total Cost of Care ($PMPY) --> BETTER
MA Outperforms FFS

Medicare Advantage outperforms FFS

ALL 10 clinical quality measures ACROSS 17 regions

Source: https://atlas.iha.org
Patients Live Longer with MA

- 6% better survival rate
- 6% preventable readmission rate
- 11% fewer hospital admissions and emergency room visits

Source: “Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival” by AK Mandal, et al. American Journal of Managed Care Vol 23, No 2; 2017
What is SOE®?

• Voluntary, self-assessed and web-based survey to capture attributes of the coordinated model of care at PO level

• Blueprint for assessing the tools and processes needed to meet:
  • strategic organizational priorities
  • increasing expectations of patients & payers

• Five publicly reported domains
  • Care Management Processes
  • Health Information Technology
  • Accountability and Transparency
  • Patient Centered Care
  • Advanced Primary Care

• Physician groups are publicly reported by star system
• Released in early March w/ 6-week completion--due late April
• Processing, scoring and auditing in early May by NCQA
• Final thresholds determined by clinical committee
• For more information: www.apg.org/soe
SOE® by the numbers...

- 12th year
- 122 groups participated
- 11 first-time SOE participants
- 12.9 million Commercial lives
- 3.2 million Medicare Advantage lives
- 3.7 million Medicaid lives
- 87 Elite members in 2018
- 71% of SOE® participants made Elite designation
  - Increase of almost 10 % pts compared to 2017
- 6 new organizations achieved Elite status
APG “SOE” Elite Perform 31% Better

SOE Groups do better on total scores than all other measured groups in IHA

Source: Integrated Healthcare Association
A sub-group of the capitated-delegated model consists of about 15 entities that possess partial Knox Keene licenses to assume "global risk".

Global Risk is a combined capitated payment for both the professional and hospital risk.

2.6 million Californians
IPA established in 1989

230+ Primary Care Physicians
570+ Specialists
30 Specialties
350 Clinic Locations
36 Communities
20 Urgent Care locations
11 Hospitals
Dual Risk Capitation Opportunity

- Best way to align the incentives of the providers
- Best way to deliver health care
- Best way to manage the cost of health care
- Best way to encourage quality innovation
Dual Risk Capitation

- Hospital Cap: 35%
- Physicians: 35%
- HMO Administration, Profit and Benefit Riders (e.g., Prescription): 30%

Shared Surplus = Aligning Incentives
Managing Dual Risk

• Requires an excellent partnership between Medical Group and Hospital

• Experienced UM, Discharge Planning, Population Health, Case Management, Disease Managers, Chronic Care Management, Hospitalists and End of Life Program

• Physician and hospital culture to manage care to the highest quality in the most cost-effective setting and method

• Forum of key executives to resolve issues early and to innovate care delivery

• Functional incentive arrangement
INTEGRATED CARE PROGRAMS
- Referral Management
- Home Palliative Care Program
- Home Health Services
- Home Infusion
- Spine Zone
- Comprehensive Pain Management

CASE MANAGEMENT
Inpatient & SNF  Complex, Transplant & Chronic Care

COMMUNITY CONNECT
Electronic Health Record
Clinical Decisions Support/ Collaborative Care
FMH Patient Portal - Personal Health Record
Essette - Care Management Platform

Other Data Sources
Sharp Healthcare Data Warehouse
San Diego Health Information Exchange
Health Plan Data (i.e. SHP Health Edge, UHC IPA)
Comprehensive care management for members with complex medical or psychosocial conditions.

Programs: IOCP2, Transplant, Complex and Basic

Post Discharge
Ensure patient transition from Hospital to home is smooth and uninterrupted. Reduce avoidable readmissions

Disease Management
3 Levels of Health coaching to provide interventions and education for patients with chronic conditions such as: Diabetes, CHF, COPD, CAD, CKD, HTN, Asthma

Medication Therapy Management
Assist physicians with patient medication adherence and the management of medication therapy. Anticoagulation/DOAC, Medication Reconciliation and Metric Gap

C.A.R.E
Case Management Assistance and Resource Education Program
Assist physicians in locating state, federal and community resources that may help meet their member’s needs

Additional Programs Available
- AGILE Texting
- Telehealth
- Diabetes Prevention
- Behavioral Health/ Social Work
Future Considerations

• Integrated EHR with patient portal

• Telehealth Expansion

• Social Determinants
Delegated Model

**PROS**

- Risk assumption works best when coupled with measurement and reporting of outcomes
- Assumption of greater risk can lead to better efficiencies

**CONS**

- Stable enrollment over time to manage risk
- Multi-payer arrangements
- Necessary infrastructure to manage population health and compliance requirements
Challenges & Opportunities

- Buried under audits
- Declining Commercial HMO enrollment
- Fighting specialty provider roll-ups and monopsonies
- Increasing operational overhead

- Steady increase in Medicare Advantage enrollment with great performance scores
- Still the most effective way to organize providers into coherent networks that deliver value
Beyond California

Other states follow different regulatory schemes than the Knox Keene Act, more closely tied to model acts under the National Association of Insurance Commissioners (NAIC).

Interest among providers to assume global risk arrangements in Medicare Advantage.

Proliferation of the capitated-delegated model across the United States.
Thank You!

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