

Sustaining Universal Coverage Through California's Integrated Care Delivery System

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Introduction

We have proposed providing universal coverage for all Californians through a tax on hospitals, health insurers, pharmaceutical sales, large medical groups, and other providers combined with expanding an employer pay or play mandate based on the successful Healthy San Francisco program initiated by current Governor Gavin Newsome when he was mayor of San Francisco.⁵ A major issue in extending such coverage is its affordability and sustainability over time. This issue is particularly salient given the aging of the population with associated increase in people with multiple chronic illnesses; the development of new drugs and treatments; and the growth of distributed care models using digital applications, telehealth applications, hospital at home and related innovations. These developments underscore the growing need for models of coordinated care delivery that make the most efficient use of resources in meeting patient needs and preferences across conditions, providers, and settings over time.

This Brief highlights 1) California's comparative advantage in having a large number of integrated care model physician organizations; 2) provides evidence on their ability to provide lower cost, higher quality value-based care; and 3) proposes a plan for expanding such models across the state to meet the ongoing needs and preferences of all Californians that will have universal health insurance coverage.

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⁵ http://petris.org/wp-content/uploads/2019/02/The-Cost-and-Financing-of-Universal-Coverage-in-California_13Feb2019FINAL.pdf

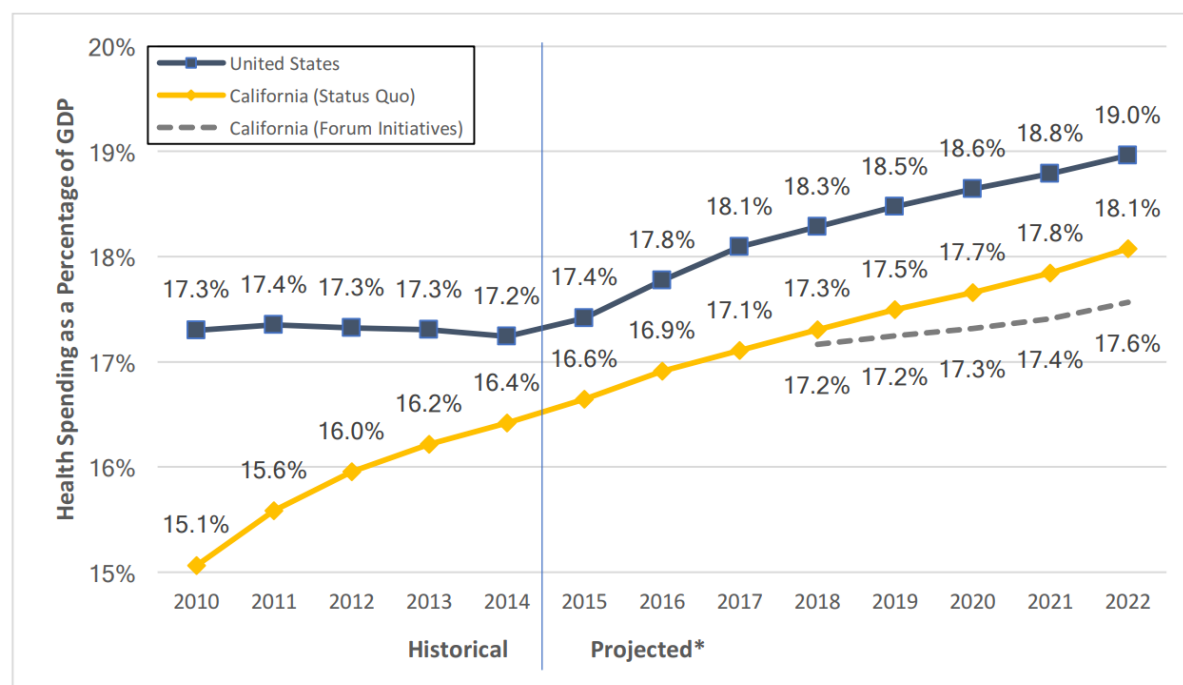
California's Integrated Care Models

The state's health care delivery system has been heavily influenced by Kaiser Permanente (KP) – a prepaid fully capitated and integrated health plan that owns its own hospitals and has an exclusive relationship with the Permanente Medical Groups. Founded in 1945, KP currently has approximately eight million enrollees in the state representing approximately 40 percent of the commercially insured market. In response, California physicians have organized themselves into over 300 medical groups increasingly accepting risk based payment and many with close affiliations with hospitals and health systems through the medical foundation model. Approximately 200 of these have participated in the pay for performance program initiated by the Integrated Healthcare Association (IHA) in 2003. The experience gained in redesigning care to meet these performance targets has enabled many of them to take on increased levels of financial risk, either for professional services only or for both professional and hospital/facility services in their contracts with insurers. As documented in the 2013 Berkeley Forum Report, 58 percent of Californians were then receiving their care from an integrated care model physician organization.⁶

An updated analysis (see Figure 1 and Table 1) shows health care expenditure reduction from expanding the number of people receiving their care from such models operating under global budgets combined with related initiatives in increasing the use of patient centered medical homes and palliative care. As shown, health care expenditures as a percent of the State's Gross Domestic Product (GDP) would be reduced in 2022 from a projected 18.1 percent to 17.6 percent compared to 19 percent for the country as a whole. This is a savings of \$12.32 billion in 2022 and cumulative savings of \$35.8 billion over the 2019-2022 time period. Such forecasts however, rest on the assumption of the ability of such organizations to continue to redesign care to reduce costs while maintaining or improving quality. As discussed below, there is recent evidence that the forecasted projections are realistic.

⁶ <http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/A-New-Vision-for-California%E2%80%99s-Healthcare-System.pdf>

Figure 1: California versus the United States: Historical and Projected Health Care Expenditures



Source: Authors' analysis of CMS Office of the Actuary's health expenditure accounts data.

Source: Scheffler RM, Fulton BD, Hoang DD, Shortell SM. Financing Universal Coverage In California: A Berkeley Forum Roadmap. *Health Affairs Blog*. March 29, 2018.
<https://www.healthaffairs.org/doi/10.1377/hblog20180327.614142/full/>

Table 1: Estimated Health Expenditure Reductions from Berkeley Forum Initiatives (\$billions)

Initiative	Description	2018	2019	2020	2021	2022	Total
Global Budgets, Integrated Care Systems	Increase the number of people who receive care from integrated care systems that operate under risk-adjusted global budgets, which encompass primary care, specialty care, post-acute care and pharmaceuticals	\$3.35	\$5.60	\$7.84	\$10.08	\$12.32	\$39.19
Patient-Centered Medical Home	Increase use of patient-centered medical homes to more effectively manage care for patients with chronic diseases and to reduce their avoidable / non-urgent emergency department and inpatient visits	\$0.12	\$0.62	\$1.13	\$1.64	\$2.15	\$5.66
Palliative Care	Increase use of concurrent curative and community-based palliative care for seriously ill patients, including advanced care planning and physical, emotional and social support	\$0.09	\$0.31	\$0.53	\$0.74	\$0.96	\$2.64
Total Berkeley Forum Initiatives' Health Spending Reductions		\$3.56	\$6.53	\$9.50	\$12.46	\$15.43	\$47.49

Source: Authors' analysis of CMS Office of the Actuary's health expenditure accounts data.

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The Evidence

Figure 2 shows the difference in quality of care and total cost of care per member per year for those physician organizations assuming no risk, professional risk only, and full risk for both professional risk and hospital/facility risk. The data are based on 7.2 million lives covered by the seven major health plans in the state excluding KP. As shown, the difference in the total cost of care for the full risk physician organizations and the no risk organizations is \$161 per member per year (\$4,589 - \$4,428). The difference between the professional risk only physician organizations and the full risk organizations is \$73 per member per year (\$4,501 - \$4,428). It is estimated that 21,414,031 Californians (63 percent) currently receive their care from either commercial HMO full risk enrollment, Medi-Cal managed care organization enrollment, or Medicare Advantage enrollment. If this could be increased to 90 percent or 30,591,473 Californians, the savings in moving the 9,177,442 of the population from no risk models to full risk models would be \$1.48 billion. Moving 50 percent of the population from no risk to full risk and 50 percent from partial risk to full risk would result in savings of \$1.07 billion. While geography and clinically risk adjusted data are not available for pharmaceutical costs, overall pharmacy costs were highest for the no risk providers at \$970 per member per year versus \$882 for professional risk only, and \$840 for the full risk physician organization provider group.⁷ At the same time, the data in Figure 2 show that the clinical quality scores actually increased from 57.9 percent for the no risk physician organizations to 65.6 percent for the professional risk only groups to 67.1 percent for the full risk physician organizations.

⁷ Atlas 3.0 data from the Integrated Healthcare Association <https://atlas.iha.org/>

Figure 2: Cost and Quality Estimates by Risk Sharing Arrangement in California



Source: Integrated Healthcare Association, 2019

The above findings are consistent with a growing evidence base on the impact of moving away from fee-for-service payment to total capitation or global budgets to contain costs.⁸ When provider organizations know in advance the resources they have to spend rather than being tied to fee-for-service piece rate payments they are motivated and are free to innovate in redesigning care to meet patient needs and preferences.

Our interviews with leaders of five physician organizations identified a number of examples.⁹ These included the use of clinical psychologists and social workers embedded into primary care practices to better integrate behavioral health into primary care; using specially trained nurses as care managers for high cost/high complexity patients; using community health workers to outreach to patients for preventive care and referral follow up; using telehealth to

⁸ Haber S., and Bell H. "Another Look at The Evidence on Hospital Global Budgets in Maryland: Have they Reduced Expenditures and Use?" Health Affairs Blg, May 14, 2018.

⁹ http://petris.org/wp-content/uploads/2019/02/California-Dreamin_White-Paper_Feb-8-min.pdf

reach patients in rural areas; and coaching on how to use the electronic medical record to facilitate ongoing communication with patients.

Spreading/Scaling Up the Integrated Care Model for All Californians

Given the evidence on the ability of integrated care model physician organizations to provide value-based care at relatively lower cost and higher quality, how might all Californians benefit from receiving their care from such organizations?¹⁰ Specifically, how might the estimated 3.72 million uninsured, including an estimated 1.5 million undocumented immigrants, benefit once universal coverage is achieved? While some of the savings discussed above will be achieved through continued growth of full risk based integrated care models serving those currently insured, we focus primarily on the implications for those currently uninsured.

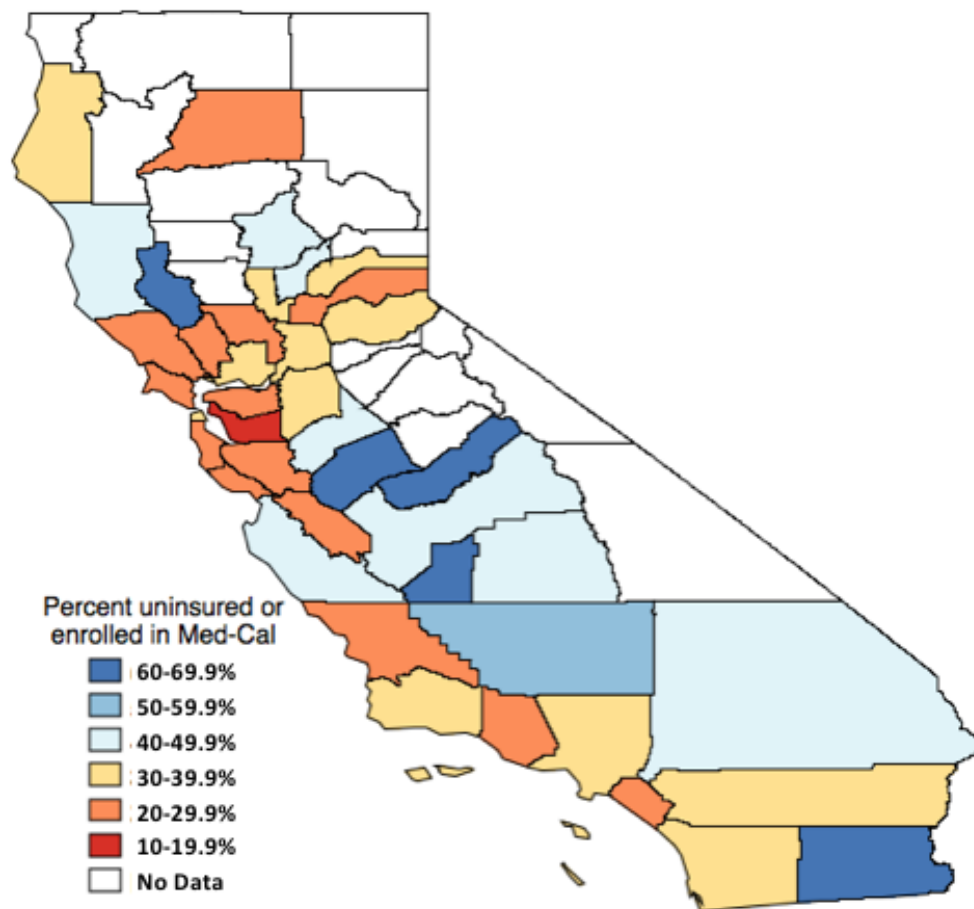
To help target the location of the uninsured with the location of physicians practicing in integrated care model physician organizations, Figure 3 shows the distribution of the uninsured and those enrolled in Medi-Cal by county, and Figure 4 shows the percent of physicians in health systems or medical groups by county. The light blue and dark blue counties in Figure 3 are counties with a high percentage of uninsured and people on Medi-Cal, while the beige, orange, and red areas in Figure 4 are counties where there are a relatively low percent of physicians practicing in organized systems of care. In some counties such as Fresno where 49 percent of people are uninsured or on Medi-Cal there is also an above median percent of physician practices in organized systems of care. These counties have the potential for providing clinically integrated coordinated care to an expanding number of people who have insurance coverage. In contrast, Kern county has 55 percent of its population uninsured or on Medi-Cal but a below median - only 44 percent - of its physicians practicing in organized systems of care. Likewise, Merced county has 61 percent of its population uninsured or on Medi-Cal with only 44 percent of its physicians in organized systems of care. These counties are likely less able to provide

¹⁰ Also see: [1] Reiss-Brennan, Brenda, Brunisholz, Kimberly D., Dredge, Carter, Briot, Pascal, Grazier, Kyle, Wilcox, Adam, Savitz, Lucy, and James, Brent. "Association of Integrated Team-Based Care with Health Care Quaiy, Utilization, and Cost". JAMA, 2016;316(8):826-834.

[2] Asarnow, Joan R., Rozenman, Michelle, Wiblin, Jessica., and Zeltzer, Lonnie. "Integrated Medical-Behavioral Healthcare Compared with Usual Primary Care for Children and Adolescent Behavioral Health: A MetaAnalysis". JAMA Pediatrics . 2015;169(10):928-937.

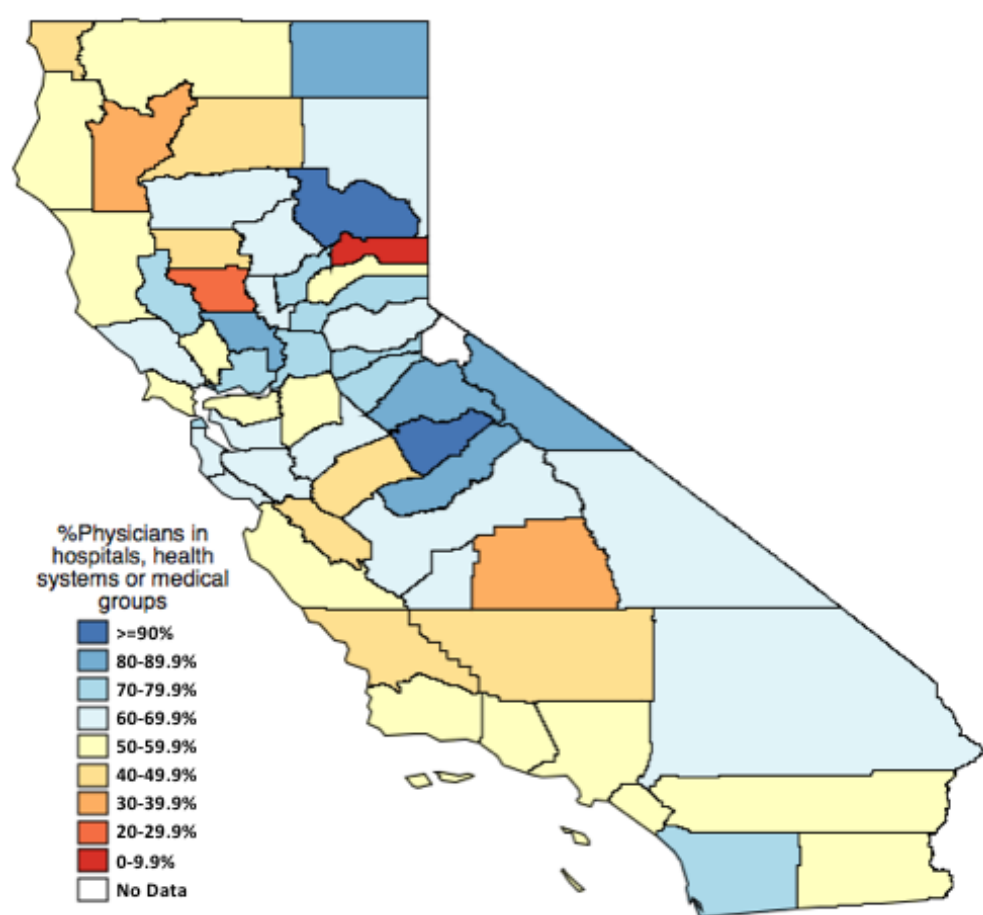
coordinated clinically integrated care. They are targets for technical assistance such as that represented by the partnership between Blue Shield of California and the California Medical Association (CMA) in Monterey and Yuba counties.

Figure 3: Percentage of population uninsured or enrolled in Medi-Cal by county in California, 2017



Source: California Health Interview Survey (CHIS), 2017

Figure 4: Percentage of Physicians in hospitals, health systems or medical groups by county in California, 2018



Source: SK&A data by IQVIA, 2018

To ensure that all Californians have access to clinically integrated organized systems of care will require expanded and ongoing technical assistance to the small largely rural, but some urban, practices in the State. Such support is currently provided by the CMS funded Practice Transformation Initiative (PTI) undertaken by the Pacific Business Group on Health (PBGH) and the California Quality Collaborative (CQC).¹¹ They are currently providing assistance to approximately 4,400 physicians in 13 physician organizations including solo practices, those belonging to independent practice associations (IPAs) and federally qualified health centers (FQHCs). They provide a practice coach who trains physicians and their staff in helping to stratify patients by degree of illness; use of clinical guidelines; implementation of electronic

¹¹ <http://www.calquality.org/programs/practice-transformation/tcpi-pti>

health records (EHRs); training in patient engagement and follow up; and related care redesign and care management capabilities. Results to date, show that 22,000 people with diabetes have improved HbA1c control; 14,300 people with diabetes and hypertension have improved blood pressure control; 44,700 inpatient days have been avoided; and 12,000 emergency department (ED) visits resulting in overall savings from unnecessary hospitalizations and testing of \$171 million.¹² Similar savings of \$61 million (2014 dollars) have been achieved by the California Right Care Initiative (RCI) in targeting physician practices to improve care for people with cardiovascular disease (CVD), stroke and diabetes through monthly “university of best practices” learning collaboratives.¹³ Early evaluation of four State Innovation Model (SIM) awards have further underscored the importance of technical assistance and providing data feedback in achieving reductions in hospital use and in one case, reducing and slowing the rate of growth in Medicaid costs.¹⁴

Given that approximately 75 percent of people who are on Medi-Cal or uninsured currently receive their care from FQHCs or related community health centers distributed throughout the state (see Figure 5) it will be important to include them in plans to expand practice sties with the ability to provide clinically integrated care. Federally Qualified Health Centers do well in providing primary care to their patients but are often challenged in coordinating care with specialists, hospitals, and post-acute care facilities.

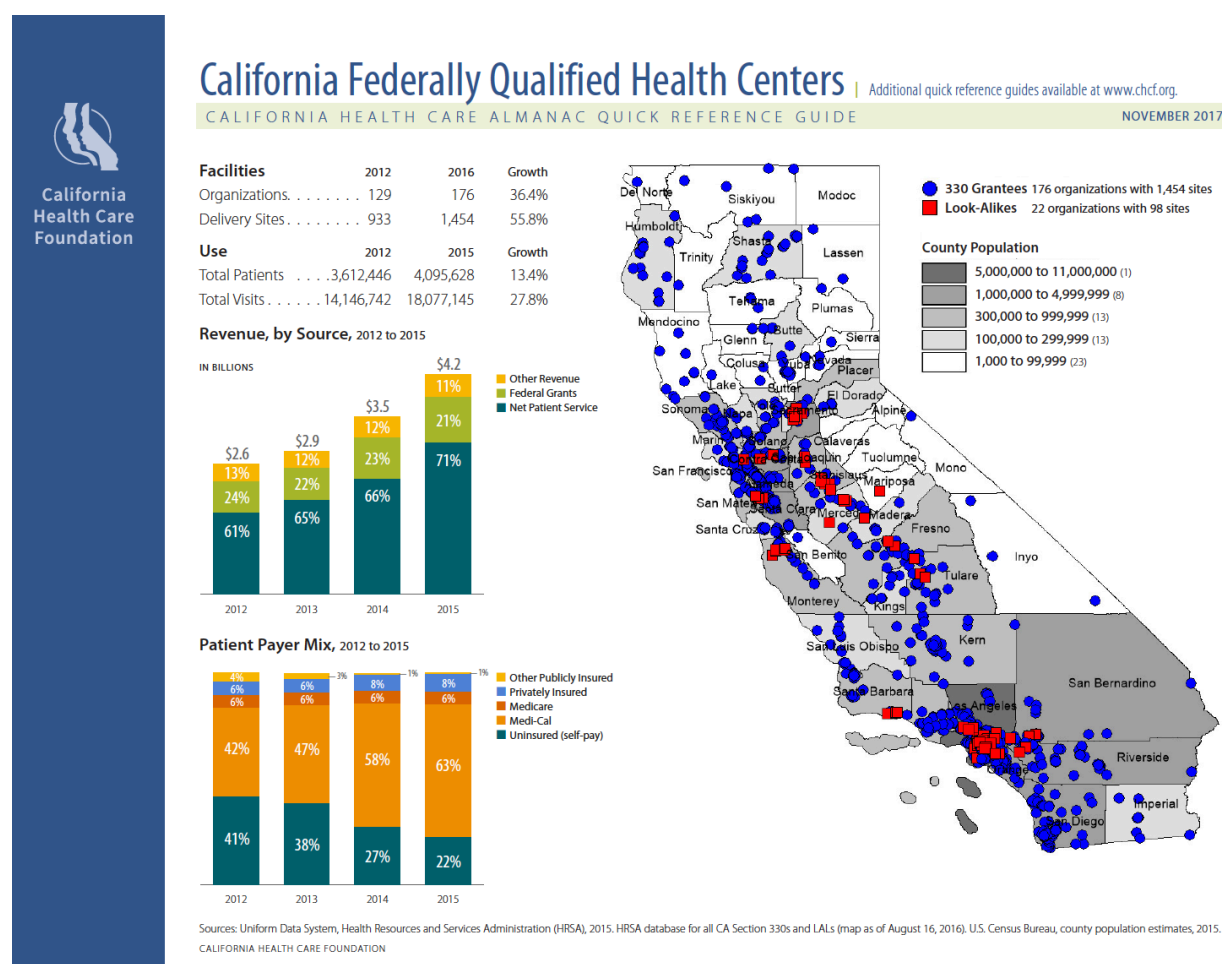
¹² <http://www.calquality.org/programs/practice-transformation/tcpi-pti>

¹³ [1] Fulton, Brent D., Susan L. Ivey, Hector P. Rodriguez, and Stephen M. Shortell. "Countywide physician organization learning collaborative and changes in hospitalization rates." *American Journal of Managed Care*, 2017;23(10): 596-603.

[2] Fremont, Allen, Kim, Alice Y., Hanley, Hattie Rees., Thorne, Christine., Dudl, James R., Kaplan, Robert M., Shortell, Stephen M., and DeMaria Anthony N., “One in Five Fewer Heart Attacks: Impact, Savings, and Sustainability in San Diego County Collaborative” *Health Affairs*, September, 2018; 37(9).

¹⁴ Rutledge, Regina I., Melissa A. Romaine, Catherine L. Hersey, William J. Parish, Stephanie M. Kissam, and Jennifer T. Lloyd. "Medicaid Accountable Care Organizations in Four States: Implementation and Early Impacts." *The Milbank Quarterly* (2019).

Figure 5: California Federally Qualified Health Centers



Source: California Health Care Foundation, 2017

Conclusion and Recommendations

A recent California Healthcare Foundation and Kaiser Family Foundation poll revealed that universal coverage is a universal value in the state and that “Californians are desperate for relief from the high cost of health care”.¹⁵ As documented in our prior Brief, universal coverage in California is within reach without waiting for the political uncertainty of various proposals advanced by presidential candidates.¹⁶ As highlighted in this Brief, California is in the unusually

¹⁵ <https://www.chcf.org/blog/what-matters-most-to-californians/>

¹⁶ http://petris.org/wp-content/uploads/2019/02/The-Cost-and-Financing-of-Universal-Coverage-in-California_13Feb2019FINAL.pdf ;; http://petris.org/wp-content/uploads/2019/02/California-Dreamin_White-Paper_Feb-8-min.pdf ;; <https://www.healthaffairs.org/doi/10.1377/hblog20190207.806149/full/>

advantageous position of having a care delivery system able to constrain the rate of growth in health care costs over time' thus continuing to make universal coverage more affordable for all.

To make affordable value- based care universally available to all Californians the state should act in four areas. First, expand coverage to all Californians through readily available means.¹⁷ Second, move as quickly as possible to fully capitated risk-adjusted total cost of care global budgets in negotiations between insurers and providers in the state. KP has decades of experience in providing care under such a payment model. The three other large insurers in the state – Anthem Blue Cross of California, Blue Shield of California, and Centene/HealthNet – have increasing experience in forming relationships with provider networks providing care under Accountable Care Organization (ACO) and related value-based payment models. An example of a step in this direction is provided by a bill that would authorize two five year pilots in Southern and Northern California in which some California School Employers would contract with integrated risk-bearing providers and pay global capitation as part of their existing plan provider networks.¹⁸ Third, as discussed above, provide support to PBGH, CQC, RCI and related organizations targeting assistance to practices with the potential to expand coordinated clinically integrated care models to areas of the State currently in need. In doing so, ensure that these organizations work with FQHCs and community health centers in developing coordinated care relationship with specialists, hospitals, and post-acute care facilities. Finally, all of the above recommendations will benefit from implementation of a State-wide All Payer Claims Data Base (APCDB) to provide transparency and accountability for the State's investment in its health care system.¹⁹

¹⁷ http://petris.org/wp-content/uploads/2019/02/The-Cost-and-Financing-of-Universal-Coverage-in-California_13Feb2019FINAL.pdf

¹⁸ [AB-1249](#) Health care service plans: regulations: exemptions.

¹⁹ <https://www.chcf.org/blog/all-payer-claims-database-california/>

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Online Resources:

- [1] <https://atlas.iha.org/>
- [2] <http://www.calquality.org/programs/practice-transformation/tcpi-pti>
- [3] <https://www.chcf.org/>