Referral Management and Disease Management in California’s Accountable Care Organizations

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INTRODUCTION

The principles underlying Accountable Care Organizations (ACOs) are not new to California. Indeed, the state has a long history of multispecialty physician groups, population-based methods of reimbursement and quality improvement initiatives reimbursed through pay-for-performance. National policy and purchaser efforts to promote ACOs should be most successful in the Golden State. Over the past decade, however, prepaid physician organizations have been losing market share in California as consumers switch to Preferred Provider Organization (PPO) insurance featuring high deductibles, fee-for-service payment and only limited quality improvement initiatives.

Enrollment in Medicare Advantage continues to grow, but only slowly, and the majority of beneficiaries remain attached to the traditional Medicare fee-for-service (FFS) program. If the principles of managed care, now rebranded as accountable care, are to retain their leading role in California, well-established physician organizations must find ways to attract and manage the care of these patients.

Medical groups in California are now seeking to extend care management capabilities from patients enrolled in commercial HMO and Medicare Advantage with Prescription Drug (MAPD) plans to consumers who have chosen commercial PPO and Medicare FFS coverage. To succeed, they must adapt their methods of care management to an environment in which patients are less attached to particular providers, reimbursement offers relatively weak rewards for efficiency and consumers evince only a limited appetite for change. They must engage physicians and other care providers who traditionally have stayed away from managed care and convince them accountable care is different and better. This Issue Brief describes the challenges facing medical groups in California as they seek to extend care management under the rubric of accountable care. It distinguishes two dimensions of care management:

- Referral Management
- Disease Management
• channeling patient choices among particular providers and facilities, denoted here as referral management, and
• coordinating the services provided to patients with multiple chronic conditions, or disease management.

The term Accountable Care Organization used here refers narrowly to contracts related to commercial PPO and Medicare FFS patients, to the exclusion of HMO and MAPD enrollees.

REFERRAL MANAGEMENT: CHANNELING CHOICES

In California, there is wide variation across providers in the prices charged for inpatient and outpatient surgery, diagnostic imaging, laboratory tests and other services. It is essential that ACOs—which are responsible for the total costs of care incurred for their patients—support care providers and facilities that charge low prices while offering good quality. Physicians in California are familiar with the gatekeeping and prior authorization mechanisms developed for HMO and MAPD patients. But these same physicians can be unaware or uncooperative in applying referral management to PPO and Medicare FFS patients. Nevertheless, managing referrals to cost effective providers is essential, and is the lowest-hanging fruit in reducing expenditures for the ACO patient population.

Physician organizations can channel patients to cooperative specialists and facilities under HMO and MAPD contracts, but cannot impose comparable restrictions on patient choices under PPO and FFS relationships. ACO patients can use the services of any provider or facility. Medical groups also cannot require authorization prior to patient access to an expensive test, procedure or admission. ACOs must manage referrals using carrots rather than sticks.

PPO and FFS enrollees face significantly higher deductibles and coinsurance requirements than HMO and MAPD patients. In principle, this makes them sensitive to the potential savings from judicious choice of provider. However, ACOs are not given the authority to calibrate consumers’ cost sharing responsibility to the prices charged by the provider selected. A major question will be whether the commercial PPO plans will develop benefit designs that favor providers and facilities within the ACO’s preferred network. In the PPO framework, this could be structured as:

• a low copay for an ACO provider
• a higher copay for use of a provider not in the ACO but nevertheless participating in the large PPO network,

and
• very high cost sharing for use of other providers not participating in the PPO network.

This form of tiered cost sharing is not possible in Medicare except through MAPD plans; the Centers for Medicare & Medicaid Services (CMS) is not actively pursuing benefit re-design and tiered cost sharing in its fee-for-service ACOs. In the absence of aligned consumer cost sharing requirements, ACOs must seek to channel referrals to efficient specialists and facilities through physician suggestion. They need to convince primary care physicians to use the same specialists and facilities for their PPO and FFS patients they use for their HMO and MAPD patients. Some physicians do this as a matter of course. Others, however, do not welcome the medical groups’ efforts to channel referrals to particular specialists and facilities.

The medical groups in California traditionally have lacked data on the specialists and facilities PPO and FFS patients use, since the insurance reimbursement claims generated by those providers go only to the insurers. Now, however, the PPO plans and CMS provide ACOs with claims data on all the services used by their attributed patients, including services from providers outside the ACO. For the first time, the medical groups have an overview of the total patterns of referral and self-referral and of price and cost for these PPO and FFS patients. Although these claims data become available only with a time lag and are not useful for real-time care management, they lay the foundation for ACOs to encourage affiliated physicians to refer to specialists and facilities willing to offer discounted prices.

Physician organizations enjoy different opportunities and face different challenges in managing referrals. The groups in this study use a wide range of hospital facilities, which can complicate the contracting and referral process. HealthCare Partners and Monarch HealthCare cover a wide geographical region in Southern California, and do not have specific partnerships with particular hospital systems. Brown & Toland Physicians covers a narrow geography in San Francisco and the East Bay and wants to align with multiple hospital partners to potentially broaden future con-
tracting possibilities. This problem of referral management is less severe for vertically integrated delivery systems such as St. Joseph Heritage, but even this large entity must be wary lest its primary care physicians refer outside the network of affiliated specialists and facilities.

The importance of referral management also highlights the importance of carefully selecting the physicians included in the ACO initiative. Typically, a medical group or IPA will only list a subset of its affiliated physicians as participants. Patients who use listed physicians will be attributed to the ACO by the PPO or CMS, as the ACO becomes financially accountable for the cost of all their care. The ACO’s financial responsibility is not limited to the services directly provided by its member physicians, but extends to all the services provided by all the caregivers and facilities used by the patient.

The importance of physician network, patient attribution and referral management is highlighted in the two contrasting strategies chosen by California medical groups. Monarch HealthCare and Brown & Toland decided to limit the number of physicians participating in their Medicare ACOs to those most committed to care management for HMO and MAPD patients. They limited their sub-network to primary care physicians plus a small number of specialists, excluding oncologists and other specialists who treated very sick patients. The medical groups were selective even within their population of primary care physicians, favoring those who:

- were exclusive to the IPA
- channeled referrals within the medical group's network, and
- received high quality ratings for the care provided to MAPD patients.

To ensure referrals would go to cooperative specialists and facilities, the IPAs selected the minimum number of physicians needed to obtain the 15,000 attributed patients required for Medicare ACO designation.

In contrast, HealthCare Partners included all its employed MDs and many of its IPA physicians in its Medicare ACO network, optimizing patient membership and benefiting from economies of scale. This strategy was challenged by the characteristics of the attributed membership with a disproportionate share of dual eligible patients (eligible for both Medicare and Medicaid) and high-risk conditions compared to the reference population. It also had greater difficulty influencing the referral pattern of its IPA physicians as opposed to the employed providers. For this and other reasons, HealthCare Partners chose to leave the Medicare Pioneer ACO program and transition to the Medicare Shared Savings Program (MSSP).

St. Joseph Heritage cited similar concerns in its reluctance to participate in ACO initiatives from either commercial PPOs or the Medicare FFS program. St. Joseph Heritage continues to expand the scale of its HMO and MAPD initiatives, as these programs permit the provider organization to rigorously manage referrals by individual physicians.

**DISEASE MANAGEMENT: COORDINATING SERVICES**

Most physician organizations in California have programs to improve outcomes and reduce costs for patients with chronic conditions such as congestive heart failure, asthma and diabetes. In many instances, these programs are substituted for the health plans’ disease management programs, leading to the term “delegated model” to describe the California medical group structure.

Disease management programs were developed by medical groups for their HMO and Medicare Advantage patients, but can also be applied to PPO and FFS patients under ACO initiatives. One of the principal motivations driving commercial PPOs to develop ACO relationships is to scale back their internal programs and obtain better results by expanding the programs administered by the medical groups. The principal insurers in California supplement fee-for-service payment for PPO patients in their ACO initiatives with some form of monthly payment. For example, Aetna pays each contracting ACO a per-member-per-month fee to help support the group’s internal program. Anthem Blue Cross also pays a monthly care management fee, but limits it to patients suffering from two or more chronic conditions. Cigna provides a care coordination fee based on a per-member-per-month methodology intended to fund an embedded care coordinator. The care coordinator is employed by the medical group and helps coordinate oversight of the aligned Cigna members and also interfaces with Cigna to collaborate on case management for its chronic condition patients.

Applying disease management for patients who have selected PPO and FFS insurance can be much more difficult than in the more familiar HMO and MAPD context. Most obviously, many patients do not realize they are affiliated with an ACO. Whereas HMO and MAPD enrollees actively select a primary care physician and medical group, ACO patients are passively attributed to medical groups based on past patterns of healthcare utilization. Medicare ACOs...
are restricted in reaching out and communicating with attributed patients, since CMS interprets some outreach initiatives as potential forms of inducement that restrict the beneficiary’s choices. Moreover, the attributed ACO patients often have made explicit choices not to join HMO and MAPD plans, and are not eager for their PPO and FFS plans to adopt similar management processes.

Provider choices are reflected in insurance claims databases that underlie the attribution logic linking patients to medical groups in ACO contracts, but past data may not reflect current preferences. PPO and FFS patients often have only a weak bond to any particular physician, and shop among caregivers for different services. On average, Medicare FFS beneficiaries use the services of more than 10 different doctors each year, many of them affiliated with different medical groups. Some patients make little use of the physicians in the ACOs to which they have been attributed. For example, Monarch reports that only 5 percent of the total costs of the care incurred by its Medicare ACO patients are obtained directly from Monarch physicians. Almost 10 percent of its Medicare ACO patients do not even live in California, but used services from Monarch physicians in the previous year while on vacation in the state, causing CMS to attribute them to the group.

It is very difficult for medical groups to identify patients suffering from chronic conditions before those conditions become severe enough to precipitate an emergency admission to the hospital. Most of the health plans and some of the medical groups use predictive modeling software to elicit insights into which patients are most vulnerable. But the medical groups report that predictive modeling based on historical claims provides only limited useful information. Patients identified as being at high risk may already be in the hospital or even deceased by the time the software flags their condition, while those on the verge of an acute episode have not yet generated a stream of insurance claims.

Brown & Toland Physicians supplements its predictive modeling methodology with frequent outreach to its affiliated physicians, soliciting them to identify at-risk patients. Monarch pays affiliated physicians for each patient health risk assessment (HRA) completed, as HRAs provide much more useful information on the patients’ conditions, medications, functional ability and preferences than do the claims data. Patients complete HRAs with the active cooperation and encouragement from the doctor, who submits them to the ACO to be entered into the patient’s electronic health record. The physician’s role in generating HRAs exemplifies the importance of physician engagement for stimulating patient engagement. Three forms of physician engagement are central. The physician must:

- know which PPO and Medicare FFS patients are attributed to the ACO and eligible for the disease management programs
- know which patients have the chronic illnesses for which the ACO offers disease management programs—which requires reviewing the patient’s medical record, HRA and ACO claims data, and
- take the lead in convincing patients to participate in disease management programs.

The medical groups find that patients are often skeptical not only of the programs sponsored by their insurers, but also of the programs sponsored by the ACO. Patient trust is most frequently accorded to the physician, nurses and social workers the patient sees in the physician practice. This focus of trust on the physician rather than the insurer or ACO is particularly prevalent among elderly Medicare beneficiaries.

**LOOKING AHEAD**

ACOs in California want to find ways to extend care management programs from HMO and MAPD patients to new PPO and FFS enrollees. ACO payment initiatives are meant to support the U.S. healthcare system’s transition to reimbursement based on the total costs of care. Commercial PPO products supplement fee-for-service with shared savings incentives and monthly fees to support disease management programs. ACO initiatives bring the payment incentives for physicians treating Medicare FFS beneficiaries closer to those prevalent in MAPD plans.

The ACO initiative reflects efforts by both medical groups and the insurance plans to shift the locus of referral management and disease management from the insurance plans toward the medical groups. This welcome development follows a long period in which plans did not want to delegate care management to providers but, rather, kept the activities in house. However, the medical groups need...
to design and implement care management initiatives with an eye toward the choice-oriented culture of PPO and FFS patients. Efficiency and quality need to be pursued using carrots more often than sticks, lest there be a consumer backlash against ACOs analogous to the earlier backlash against HMOs.

Applying care management principles to PPO and FFS patients offers the potential for closer collaboration between physicians and patients, among the various physicians involved in a patient's care and between the health professionals that deliver the care and the insurers that pay for it. Shared financial responsibility encourages shared clinical responsibility. Physician organizations in California have a long history of care management for HMO and MAPD enrollees, and now have the opportunity to develop analogous initiatives for PPO and FFS enrollees. This is the opportunity and the challenge facing ACO initiatives in California.

Efficiency and quality need to be pursued using carrots more often than sticks, lest there be a consumer backlash against ACOs analogous to the earlier backlash against HMOs.

Acknowledgments
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ABOUT THIS STUDY
This Issue Brief and three others draw upon information from a case study conducted by the Integrated Healthcare Association (IHA) and researchers from the University of California at Berkeley, School of Public Health. Support for the two-year study, which was launched in April 2013, was provided by a grant from the Robert Wood Johnson Foundation® and focused exclusively on the California market. The research team conducted two rounds of structured interviews in 2013 and 2014 with five prominent Accountable Care Organizations (ACOs). It also undertook two rounds of interviews with health plan executives responsible for ACO strategy and contracting at five health plans in California: Aetna, Anthem, Blue Shield of California, CIGNA and UnitedHealthcare.

PHYSICIAN ORGANIZATIONS INCLUDED
This study focused on five physician organizations—each distinct in scale, geography, structure and ownership ties to hospitals. All are deeply engaged in ACO initiatives, defined broadly as including payment methods linked to the total cost of patient care. Some have new ACO contracts with Medicare and private insurers, while others are focused on capitation payment from Medicare Advantage, commercial HMO and managed Medicaid plans.

▪ AltaMed Health Services was founded more than 40 years ago as a grant-funded free clinic serving the Latino population in Los Angeles. It is the largest independent Federally Qualified Health Center in the U.S., delivering more than 930,000 annual patient visits to 180,000 patients through 43 sites in Los Angeles and Orange Counties. The majority of AltaMed’s patients—85,000—are Managed Medi-Cal enrollees, but it serves an additional 11,500 through Medi-Cal fee-for-service contracts. In addition, 26,000 patients are covered through commercial HMO and PPO contracts, and 5,000 are Medicare patients. AltaMed provides care through staff-model clinics with an IPA that supplements the clinic staff with community physicians. It offers primary medical care, dental care and senior long-term care services.

▪ Brown & Toland Physicians is an Independent Practice Association (IPA) founded in 1992 in San Francisco, with a recent expansion into the East Bay market. Its 1,500 physicians care for more than 34,000 Medicare patients—including 16,000 through Medicare Advantage and 18,000 through its Pioneer ACO contract. It also serves 100,000 commercial HMO patients through capitation contracts; 175,000 commercial PPO patients; and 2,700 Medicaid managed care enrollees. Brown & Toland partners with several hospitals in the area, including Sutter, where many admits come from California Pacific Medical Center and Alta Bates Summit Medical Center. It also partners with other area hospitals—including Dignity Health, the University of California, San Francisco and the Alameda Health System.

▪ HealthCare Partners, a division of DaVita HealthCare Partners, manages and operates HealthCare Partners Medical Group in California along with organizations in Arizona, Colorado, Florida, Nevada and New Mexico. In California, HealthCare Partners serves 175,000 Medicare patients, including 125,000 through Medicare Advantage, and the remainder through its Medicare Shared Savings Program (MSSP) ACO and the Medicare fee-for-service program. It also serves 100,000 commercial PPO patients, 400,000 commercially insured HMO patients and 117,000 Medi-Cal managed care and fee-for-service patients. For HMO and Medicare Advantage patients, HealthCare Partners is paid capitation for the full range of physician and hospital services. HealthCare Partners contracts with nearly 50 hospitals in Southern California.

▪ Monarch HealthCare is an IPA that includes 640 primary care physicians throughout Orange County. It serves 61,000 Medicare patients, of which 38,000 come through Medicare Advantage plans and 23,000 through its Pioneer ACO contract, plus 61,500 Medi-Cal patients through the CalOptima managed care program and 92,000 commercially insured HMO and PPO patients, combined. It is owned by Optum, Inc., a subsidiary of the UnitedHealth Group that also has an affiliation with the UnitedHealthcare insurance plan. Monarch does not have an ownership association with any hospital system, but admits patients to all the major facilities in Orange County and Los Angeles. Through Optum, it is also involved with payment and organizational initiatives for a larger set of medical groups across the nation.
This Issue Brief focuses on findings related to four physician organizations: Brown & Toland Physicians, HealthCare Partners, Monarch HealthCare and St. Joseph Heritage Medical Group. A fifth, AltaMed, was also included in the study, but because of its unique structure as a community clinic, the results are addressed more specifically in a separate Issue Brief:

▪ **St. Joseph Heritage Medical Group** is the physician organization affiliated with the St. Joseph Hoag Health alliance in Orange County. It contains both integrated medical groups and IPAs around the four major St. Joseph Hoag facilities in the county, as well as smaller initiatives at hospitals it owns in northern California. It serves 33,000 Medicare Advantage enrollees; 151,500 commercial HMO enrollees; 3,500 Medi-Cal managed care enrollees; and 5,500 Medi-Cal fee-for-service patients. In addition, it serves 38,000 Medicare fee-for-service and 111,000 commercial PPO enrollees; these are not covered by ACO contracts and their care continues to be reimbursed on a fee-for-service basis. Together, St. Joseph Hoag hospitals and the Heritage physician groups represent the vertically integrated physician-hospital organization, contracting as a single unit with health insurers.

**RESEARCH TEAM MEMBERS**

The research team was comprised of:

▪ **Thomas R. Williams**, Dr.PH—Vice President and General Manager of Accountable Care at Stanford Health Care; Former President and CEO at the Integrated Healthcare Association

▪ **James C. Robinson**, Ph.D—Leonard D. Schaeffer Professor of Health Economics at the University of California at Berkeley School of Public Health and Director of the Berkeley Center for Health Technology

▪ **Jill Yegian**, Ph.D—Senior Vice President, Programs and Policy at the Integrated Healthcare Association

▪ **Kimberly MacPherson**, MPH, MBA—MPH Program Director, Health Policy and Management at the University of California at Berkeley School of Public Health and Co-Director of the Berkeley Center for Health Technology, and

▪ **Kelly Miller**—Project Manager at the Integrated Healthcare Association.

**ISSUE BRIEFS PRODUCED**

This Issue Brief focuses on findings related to four physician organizations: Brown & Toland Physicians, HealthCare Partners, Monarch HealthCare and St. Joseph Heritage Medical Group. A fifth, AltaMed, was also included in the study, but because of its unique structure as a community clinic, the results are addressed more specifically in a separate Issue Brief:

▪ **A Large Community Health Center Adapts to a Changing Insurance Market**, by Jill Yegian, Ph.D.

Additional Issue Briefs stemming from this study address other aspects of ACOs emerging in the state, including:

▪ **ACO Contractual Arrangements in California’s Commercial PPO Market**, by Thomas R. Williams, Dr.PH, and

▪ **Accountable Care in California: Imperatives and Challenges of Physician-Hospital Alignment**, by James C. Robinson, Ph.D.

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**Patient Enrollment at a Glance**

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*Enrollment as of August 2014*